REFORMING MEDICAID 9 | WHERE DO DEMOCRAT HOPEFULS STAND? 10-11 | SENIORS DEMAND MALPRACTICE REFORM 13

Health Care News

©2003 The Heartland Institute | The Monthly Newspaper for Health Care Reform | Vol. 3 No. 4 ~ April 2003

Thumbs Down on Smallpox Vaccine Program

Fewer than 1 percent of targeted first responders were vaccinated by February's end

Conrad F. Meier

Health care professionals nationwide are refusing to be inoculated against smallpox, worried about the vaccine's side effects and not sure the threat of a chemical attack justifies the risk posed by vaccination.

Federal officials hoped to inoculate almost 450,000 health care workers in February, the program's first month. Despite President Bush's request for voluntary participation, the vaccination rate came in at about 1 percent of the goal. As of the end of February, just 4,200 people in 27 states had been vaccinated. Many hospitals have said they will not participate.

Health and Human Services Secretary Tommy Thompson was disappointed by the response. "I think there are a lot of people who believe that it's not an issue and haven't seen any evidence that they should be concerned about a smallpox epidemic."

The first round of the federal vaccination program targeted members of first-response public health teams. They are most likely to encounter contagious patients and would be needed to care for sick people in the event of a chemical attack.

SMALLPOX continued on page 8

Photo: Robyn Beck/AFP

U.S. Surgeon General Richard H. Carmona is bandaged by Lt. Commander Lucienne Nelson after receiving a smallpox vaccine in front of the media on March 11, 2003 at the Department of Health and Human Services headquarters in Washington, DC.

Missouri Proposal Adds New Layer of Bureaucracy

Conrad F. Meier

Missouri State Senator James Mathewson (D-Sedalia) has introduced a measure he says would give the state more "buying power" by combining into a single plan the myriad health plans offered to government employees in the state.

Mathewson's opponents reject the single-payer approach as expensive and less effectively tailored to employee needs.

SB 450, introduced in the Senate Ways and Means Committee, would create a new agency of state government, the Division of Community Health, which would be empowered to combine into a single plan the various health care programs offered to government employees in the state. By putting all government employees into the Missouri Consolidated Health Care Plan (MCHCP), Mathewson said he expects to be able to increase the plan's purchasing power, thereby saving the state money.

Consolidation, according to its supporters, is advantageous because it allows government employees to benefit from what is essentially a larger group discount. They note Georgia employs a plan like the one Mathewson is proposing, and West

MISSOURI continued on page 5

Why Doctors Are Leaving Medicare

Maury M. Breecher, Ph.D., M.P.H.

Medicare recently dodged a potentially fatal "bullet," but 2003 is still a "make or break" year for the 23-year-old program that provides most of the health care for this nation's senior citizens.

Doctors throughout the U.S. had threatened to severely limit their Medicare practices if the federal government followed through with previously mandated 4.4 percent physician fee cuts this year, on top of a 5.4 percent cut physicians were made to accept last year.

A recent study by the American Medical Association (AMA) found nearly half (48 percent) of all U.S. physicians would have limited their Medicare practices if the 4.4 percent fee reduction had been implemented.

LEAVING continued on page 6

INSIDE HCN

2 Patients' Rights Debate Revived
3 Medicaire Patients Get Better Care
4 What Bush Didn't Say About Medicare
8 Obese Kids Re-Plead Their Case
12 Scandlen at Large
14 State Update
17 The Galen Report
18 Bloodletting Doesn't Work!

The Heartland Institute
19 South LaSalle #903
Chicago, IL 60603

PRESORTED
STANDARD
US POSTAGE PAID
BEAVER DAM, WI
PERMIT NO. 412

LICENSED TO UNZ.ORG
ELECTRONIC REPRODUCTION PROHIBITED

HEALTH CARE NEWS
EDITORIAL OFFICES

The Heartland Institute
19 South LaSalle, Suite 903
Chicago, Illinois 60603
312/377-4000 voice • 312/377-5000 fax
email think@heartland.org

Health Care News is available on the Internet. Point your web browser to **http://www.heartland.org**.

PRESIDENT
Joseph L. Bast

PUBLISHER
Nikki Saret

EDITOR
Diane Carol Bast

MANAGING EDITOR
Conrad F. Meier

ASSISTANT EDITORS
Greg Scandlen
Merrill Matthews

CARTOONISTS
Frank Russmo
Chuck Asay

DESIGN AND PRODUCTION
Kevin Fitzgerald
Jennifer Beranek

ADVERTISING MANAGER
Nikki Saret

CIRCULATION MANAGER
Latreece Vankinscott

CONTRIBUTING AUTHORS
Twila Brase, Bob Corkins
Dewey L. Crepeau, Dr. Miguel A. Faria
Tom Miller, Gerry Smedinghoff
Grace-Marie Turner

BOARD OF DIRECTORS
Joseph Bast, Walt Buchholtz, Robert Buford
Paul Fisher, James Fitzgerald, Dan Hales
William Higginson, James L. Johnston
Ross Kaminsky, Roy E. Marden
David H. Padden, Frank Resnik
Leslie Rose, Robert Russell
John Skorburg, Herbert J. Walberg Ph.D.
Lee H. Walker, Tom Walton

Health Care News is published 11 times per year by The Heartland Institute. Subscriptions are free to U.S residents and $24 per year for foreign residents. Order online at www.heartland.org. Heartland is a nonprofit and nonpartsan public policy research organization serving the nation's federal and state elected officials, journalists, Heartland Members, and other opinion leaders. Its activities are tax-exempt under Section 501(c)(3) of the Internal Revenue Code.

© 2003 The Heartland Institute. Nothing in this issue of **Health Care News** should be construed as reflecting the views of The Heartland Institute, nor as an attempt to aid or hinder the passage of any legislation.

Norwood Tries to Revive Patients' Rights Debate

Conrad F. Meier

Rep. Charlie Norwood (R-Georgia) is trying to revive the debate over patients' rights by proposing two new bills.

Norwood's first measure, last year's Patients' Bill of Rights Act, has been edited and renamed the Patient Protection Act (PPA). The PPA would require that managed care insurance plans provide their insureds with access to emergency and pediatric care, as well as prescription drugs.

The act would also guarantee patients access to their medical information, protect the doctor-patient relationship, and grant patients the right to an independent review if a physician and insurance company disagree on the physician's recommended plan of treatment.

The measure has been modified to reflect the Supreme Court's June 20, 2002 ruling in *Rush v. Moran* and would allow states to have more stringent independent review provisions than the minimum established by federal law. In *Rush v. Moran*, the high court upheld state laws allowing consumers to seek an independent review of denials of care by managed care companies.

According to a press release issued by Norwood's office, the second measure, called the ERISA Clarification Act, also clarifies the Supreme Court's *Rush v. Moran* decision, stating the 1974 Employee Retirement Income Security Act does not block actions against health plans for denials of care from proceeding in state courts.

Deja vu

In the 107th Congress, the House and Senate each approved patients' rights legislation, but negotiations to reconcile the two bills stalled. The Senate measure would have allowed consumers to sue HMOs in state court for unlimited damages, or in federal court with damages limited to $5 million. The House bill, supported by the Bush administration, would have permitted consumers to sue HMOs only in federal court, with a $1.5 million cap on non-economic damages.

Consumers also would have been permitted to receive up to $1.5 million in punitive damages under the House bill, but only if they had won complaints against the HMO before an outside appeals panel and the HMO still refused to cover the cost of care.

"Donald Young, president of the Health Insurance Association of America (HIAA), ... called Norwood's bills a 'bad idea whose time has passed' and 'retread proposals to exorcise yesterday's ghosts.'"

Sharply Critical

Rep. John Dingell (D-Michigan), who cosponsored a previous patients' rights bill with Norwood, said trying to pass a patients' rights measure without addressing the liability issue is "like trying to move a car forward without an engine."

Senator John McCain (R-Arizona) agreed, noting "a liability provision has to be part of any patients' rights package."

Senator John Edwards (D-North Carolina) also appeared dismissive of Norwood's proposal, saying "without enforcement, it's a patients' bill of suggestions."

Dingell, McCain, Edwards, and Senator Edward Kennedy (D-Massachusetts) are expected to propose their own versions of a patients' rights bill.

Donald Young, president of the Health Insurance Association of America (HIAA), said Norwood's legislation would further drive up health care costs, exacerbating the nation's uninsured crisis at a time when health care costs already are escalating rapidly. He called Norwood's bills a "bad idea whose time has passed" and "retread proposals to exorcise yesterday's ghosts."

Tough Sell

Norwood's bills have attracted little support to date, in part because the measures do not include a provision for suing managed care plans for medical decisions resulting in less-than-acceptable patient outcomes.

Norwood defended both his bills in a news release. "I know others will say that with health care costs on the rise, now is not the time for patient protections. But from my perspective, now is precisely the time for patient protections. When insurers and employers are concerned about the cost of health care, the quality of patient care can be jeopardized for the bottom line.

"I am no longer trying to help forge a compromise on liability," Norwood continued. "I tried that for years and, in the end, all I got was a few hundred beatings and no law."

Patients' rights legislation may be a non-starter in this session of Congress. Terrorism and international issues have demanded a substantial amount of lawmakers' attention; on the domestic front, policymakers are focused more on creating a Medicare prescription drug benefit, addressing rising medical malpractice insurance rates, and reforming the structure of Medicare and Medicaid.

Conrad F. Meier is managing editor of Health Care News.

LICENSED TO UNZ.ORG
ELECTRONIC REPRODUCTION PROHIBITED

Quality of Care for Medicare Patients Improving

Conrad F. Meier

Medicare patients appear to be getting better care for such ailments as heart attacks, pneumonia, breast cancer, and diabetes than they did a few years ago, but the quality varies dramatically by region and state.

According to Dr. Stephen Jencks, lead author of a recent quality improvement study and director of the quality improvement group at the Centers for Medicare and Medicaid Services (CMS), the report shows a small improvement in the quality of medical services offered to America's elderly over the past two years.

The proportion of the Medicare population receiving appropriate care increased from 69.5 percent during the period 1998-99 to 73.4 percent during the 2000-01 period. On average, states improved on 20 of 22 quality indicators.

Among the biggest gains were those made in the percentage of heart attack patients being sent home from the hospital with prescriptions for beta-blocker drugs. This figure rose on average from 72 to 79 percent. Another notable improvement was in the percentage of Medicare patients receiving pneumococcal vaccines, up from 55 percent to 65 percent.

"It's a significant rise. It's real. It's not just sampling error. But, gee, we do have a long way to go," said Jencks.

"Things are going in the right direction," agreed Dr. Randolph Peto, medical director for quality improvement at MassPRO in Waltham, Massachusetts. MassPRO is the quality improvement organization working under a contract from CMS. "This," adds Peto, "is one of the few national studies that can provide this amount of quality improvement information, and since the Medicare population is one of biggest patient groups out there, this is important information."

Writing in her weekly e-newsletter, *Health Policy Matters*, Grace-Marie Turner, president of the Galen Institute, notes, "The Medicare program still has a long way to go to provide seniors with the reliable medical care they need and deserve.

"Quality of care improved on 20 of 22 measures of quality from 1998-1999 to 2000-2001," Turner continued, "but still only 73.4 percent of Medicare patients received 'appropriate care,' according to the report. This means 26.6 percent of seniors are receiving inappropriate care."

The Jencks report also found wide variations in the quality of care across states and regions, and acknowledged "a wide gap remains between the care that could be delivered and the care that is delivered to Medicare beneficiaries."

Fee-for-service

The Jencks study reflected mostly fee-for-service Medicare, as opposed to managed care. *Health Care News* has learned a comparison of the two programs is forthcoming and may help fee-for-service arrangements adopt measures proven successful in the managed care model. Conversely, managed care may learn from the fee-for-service model.

The new study follows up on an initial report, released in 2000, that weighed in on 24 indicators of quality of care during 1998 and 1999. Those indicators measured delivery of various services known to prevent or treat heart attack, heart failure, stroke, pneumonia, breast cancer, and diabetes.

The new study looked at 22 indicators, including whether a mammogram was given every two years; for heart attack victims, whether aspirin was given within 24 hours of hospital admission; and, for pneumonia, whether antibiotics were administered within eight hours of the patient's arrival at a hospital. Information was gleaned primarily from claim forms but also from health care consumers themselves.

"The Jencks report also found wide variations in the quality of care across states and regions, and acknowledged 'a wide gap remains between the care that could be delivered and the care that is delivered to Medicare beneficiaries.'"

Room for Improvement

In both the initial report and the new follow-up, northern states and those with smaller populations showed better performance. However, some areas of care, such as dilated retinal eye exams to prevent blindness in people with diabetes, showed no improvement even in the better-performing states.

The two measures for which states, on average, did not show improvement were the percentage of patients receiving ACE inhibitor drugs for heart failure and those having blood cultures taken before receiving antibiotics for pneumonia.

Dr. Ken Thorpe, chairman of health policy and management at Emory University, said some doctors might disagree with the so-called "standard practice" measured by the Jencks study. For example, some may not consider ACE inhibitors to be the best treatment for heart failure patients.

Southern states rated poorly in the initial study generally remained at the bottom of the rankings. States at the top of the rankings in the initial study remained there. Specifically, New Hampshire and Vermont retained No. 1 and No. 2 status, while Louisiana, 49th two years ago, dipped to worst among the states. Puerto Rico was ranked last in both reports.

Some have speculated the regions faring poorly have a greater proportion of low-income, less healthy patients, but the researchers were unwilling to make that connection, saying the reasons for the variations remain unclear.

Private Sector Steps up

Jencks points to changes implemented since the initial report issued two years ago. "On a number of issues, there has been a substantial national consciousness-raising, particularly among the physician community," he says. "Pneumococcal vaccine and beta blockers have been particular targets."

Quality improvement initiatives instituted by The Business Roundtable's (BRT) Leapfrog Group have played a role in making health care better and safer. In March 2001, *Health Care News* reported on BRT's launch of a free-market effort to improve the quality of health care delivered to patients across the country.

BRT's Leapfrog Group is a growing consortium of Fortune 500 companies and other large private and public health purchasers. Leapfrog Group members provide medical benefits to more than 20 million U.S. employees, who in turn spend more than $40 billion a year on health care services.

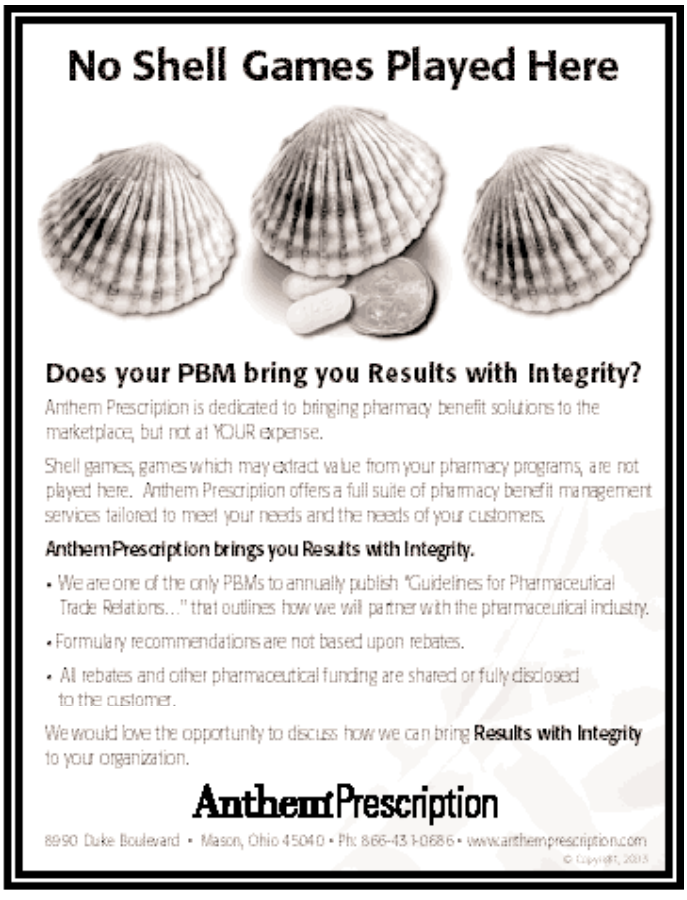
While the Leapfrog initiative is primarily directed at the non-Medicare population, the improvements have spread across the entire health care delivery spectrum. Participating Leapfrog employers have agreed to emphasize patient safety in their purchases of health care. Among the measures employed by the Leapfrog participants are:

- Computer Physician Order Entry (CPOE). CPOE allows physicians to enter medication orders through computer-linked error prevention software. Studies show the CPOE system can reduce prescription errors in hospitals by more than 50 percent.
- Evidence-based Hospital Referral. By referring patients in need of complex medical procedures to hospitals offering the best odds of survival, health care providers can improve patient outcomes by 30 percent.
- ICU Physician Staffing. Intensive Care Units staffed by physicians with credentials in critical care medicine have been shown to reduce the risk of dying in an ICU by about 10 percent.

Research conducted by John D. Birkmeyer, MD under the auspices of the Dartmouth Medical School has confirmed the three patient safety-oriented measures improve the quality of health care. And too, quality improvement organizations like MassPRO, which contract with hospitals and physicians to raise levels of service, may also have played a positive role.

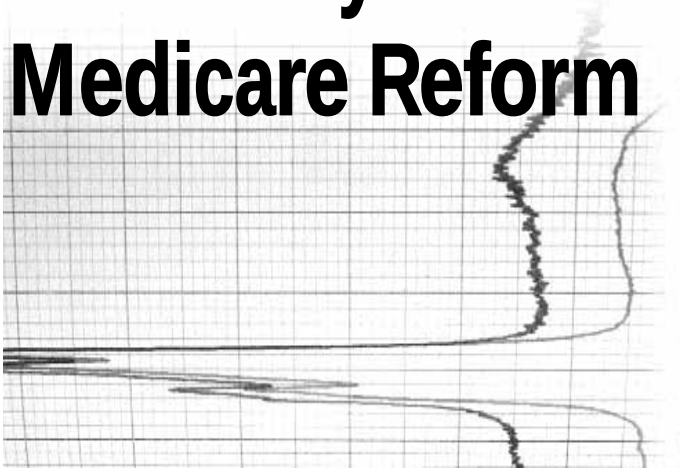
Only limited information is available on whether quality of health care is improving. The most anecdotal evidence seems to be in statistics pointing to the quality and longevity of life. The fastest growing segment of the U.S. population is the number of Americans over age 85.

Conrad F. Meier is managing editor of Health Care News.


No Shell Games Played Here
Does your PBM bring you Results with Integrity?
Anthem Prescription is dedicated to bringing pharmacy benefit solutions to the marketplace, but not at YOUR expense.
Shell games, games which may extract value from your pharmacy programs, are not played here. Anthem Prescription offers a full suite of pharmacy benefit management services tailored to meet your needs and the needs of your customers.
Anthem Prescription brings you Results with Integrity.
• We are one of the only PBMs to annually publish "Guidelines for Pharmaceutical Trade Relations..." that outlines how we will partner with the pharmaceutical industry.
• Formulary recommendations are not based upon rebates.
• All rebates and other pharmaceutical funding are shared or fully disclosed to the customer.
We would love the opportunity to discuss how we can bring Results with Integrity to your organization.
Anthem Prescription
8990 Duke Boulevard • Mason, Ohio 45040 • Ph: 866-431-0686 • www.anthemprescription.com

LICENSED TO UNZ.ORG
ELECTRONIC REPRODUCTION PROHIBITED

What Bush Didn't Say about Medicare Reform



Tom Miller

President Bush appears to be struggling to settle on a Medicare reform plan that can dodge political bullets yet still deliver results that make a difference.

His State of the Union address and follow-up speech in Michigan reiterated his support for a new (and more expensive) prescription drug benefit for seniors, but it also proposed more basic restructuring of the 38-year-old health care program.

Four Objectives

If the President hopes to get Medicare out of reform school, he will need to move beyond a few sentences of sketchy platitudes and bland principles. He should concentrate on four key objectives:

- Get the overall program structure and its incentives realigned correctly and worry about budget savings later.
- Structurally integrate the various portions of the antiquated Medicare program (Part A for hospital care, Part B for outpatient care, Part C for private plan options) into a single package.
- Spend political capital to set Medicare payments according to indicators of market-based prices, instead of administered price controls. Some early, if limited, version of competitive bidding should determine prices and reimbursements and establish level-playing-field competition between the traditional Medicare program and private plan alternatives.
- Provide strong economic incentives for Medicare beneficiaries to choose lower-cost private plan options.

For the past two years, the Bush administration was content to make statements of broad Medicare reform principles that promised new benefits for prescription drugs and preventive care but mostly downplayed structural changes needed to keep the program affordable and sustainable.

Collision with Reality

This year, the President again promised seniors that, if they are happy with current coverage, they could keep their Medicare "just the way it is."

Yet the traditional Medicare program only pretends to offer beneficiaries unlimited choice of fee-for-service medicine. Mounting fiscal pressures force the program to hollow out that promise—through price controls, outdated benefits, and complex reimbursement rules.

Traditional calculations of Medicare's trust fund solvency don't capture the full dimen-

Medicare-for-all Plan Headed for Congress

Sydney Smith, MD

A disconcerting letter has been circulating among physicians recently. It's from a group called Physicians for a National Health Program (PNHP). You might have heard of them. Their chief spokespersons are Dr. Marcia Angell, a former editor of *The New England Journal of Medicine*, and Dr. Quentin Young, a public health activist.

The two have been busy making the rounds of talk shows and writing op-eds to publicize their crusade for a national health insurance program. Even Rex Morgan, M.D. is a member. In fact, the current story line of the daily comic strip has him attending a PNHP convention. Unfortunately, unlike Dr. Morgan, the group's agenda isn't confined to the comic pages.

The letter announces that a national health insurance bill will soon be introduced in Congress, crafted by members of PNHP and sponsored by Rep. John Conyers Jr. (D-Michigan). The bill would, according to the group and the Congressman, expand our current Medicare system to include everyone. It would control skyrocketing health costs, cover all 42 million uninsured Americans, restore free physician choice to patients, and provide comprehensive prescription drug coverage to everyone. And it would save the nation at least $150 billion annually.

Sounds Wonderful

Few would reject such a wonderful proposal ... that is, until they've read the text of the bill. Some of its high points:

- The government would purchase all hospitals, nursing homes, and physician practices.
- The government would allot every hospital, nursing home, and physician practice a yearly operating budget.
- The government would determine the rate of reimbursement for services.
- The government would determine the prices of drugs, medical supplies, and medical equipment.
- Patients would bear no direct responsibility for paying for health care services ... but all would pay higher taxes.
- The program would cover everything but "cosmetic" medicine.
- It would be financed by a progressive tax structure, including, among other things, a "health income tax" on the wealthiest 5 percent of the population.

The PNHP/Conyers plan would be implemented and overseen by a gargantuan bureaucracy of regional and state health insurance administrators, at the head of which would be a director chosen by the secretary of Health and Human Services. The director would be assisted by an advisory panel selected by the President and made up of health care professionals, health care groups, and health "advocacy" groups. The potential for political meddling is unlimited.

Recipe for Disaster

This is much more than an expansion of Medicare. It's a Socialist manifesto. It's also a sure-fire recipe for disaster. It encourages unlimited demand for health care services while severely limiting the ability of physicians to provide them.

Is there any doubt that the $150 billion in savings would be had by slashing reimbursement rates and operating budgets? And what about the cost of financing the bureaucracy that administers this program? One gets the impression the people who crafted this proposal have never had to manage a medical practice or struggle with Medicare reimbursement.

"[Comic strip physician] Rex Morgan may be the only member of Physicians for a National Health Program who owns a medical practice. The majority of its membership is made up of academics, public health physicians, and medical students; people who most certainly have never had to meet a payroll."

In fact, Rex Morgan may be the only member of Physicians for a National Health Program who owns a medical practice. The majority of its membership is made up of academics, public health physicians, and medical students; people who most certainly have never had to meet a payroll.

Marcia Angell, no matter how impressive her credentials, does not speak from experience when it comes to running a practice. As to Quentin Young, he claims to have a long-standing private practice in Chicago. A review of his biographical information, however, indicates that for the past 20 years he has devoted himself largely to public health and advocacy. Chances are it's been a very long time since Dr. Young had a hand in managing a practice.

Taken at face value, the goals of the group are admirable—but there are better ways to achieve them than the complete government take-over of medicine. The American Medical Association, for example, has a plan worthy of consideration. It would divorce health insurance from employment by giving individuals the same sort of tax credits businesses currently get for purchasing health insurance. It keeps the financial control of hospitals and physician practices in the hands of those who run them. It encourages fiscal responsibility on the part of the patient. And it relies on the free market rather than the government.

The members of Physicians for a National Health Program argue health care isn't a commodity, but a service that should be distributed from each according to his ability, to each according to his need. But health care *is* a commodity, just as surely as food and shelter are commodities.

No one would seriously suggest we put the government in charge of producing and purchasing our bread and housing. We shouldn't put them in charge of our health care, either. It might work on the comic pages, but it's already failed miserably in the real world.

Dr. Sydney Smith is board certified by the American Board of Family Practice, a fellow of the American Academy of Family Practice, and publisher of MedPundit. This article was first published by Tech Central Station and is reprinted here with permission.

LICENSED TO UNZ.ORG
ELECTRONIC REPRODUCTION PROHIBITED

sions of the imminent collision ahead between the demands of an entitlement program set on autopilot and the financial resources available to sustain those demands.

The most recent annual Financial Report of the U.S. Government estimated the net present value of negative cash flow (the funds needed to cover projected shortfalls) over the next 75 years for Medicare is $12.8 trillion. The fiscal year 2004 budget proposed by Bush projects about $13 trillion. Both figures assume no new drug benefits.

Now Is the Time

The latest opportunity to start serious restructuring of the overall Medicare program should not be squandered. With Republicans back in at least nominal control of both houses of Congress, the Bush re-election team and other GOP candidates in 2004 will find it more difficult to tell seniors again that the "Democratic dog ate my Medicare drug homework."

Serious Medicare reform will be difficult. A host of traditional political obstacles urge us to "stop thinking about tomorrow." The Bush administration also must overcome the legacy of past flawed reform efforts, which triggered the meltdown of Medicare+Choice private plan options, and the tendency for promises of new and improved benefits to drown out the need for structural changes that set limits and require tradeoffs.

In late January, Bush appeared ready to propose a three-tiered menu of Medicare options that would limit expanded drug coverage to those seniors who move to new types of private plans and are willing to pay more for better benefits. But simply trying to hook seniors on private insurance plans by offering them drugs is not going to fly—either politically or commercially.

Most current beneficiaries will resist offers to leave an unreformed traditional Medicare program, even if the availability of private plan alternatives improves. Five years' experience with a shrinking Medicare+Choice program should convince policymakers the program needs both a modernized benefits carrot and a market pricing stick. Fear of change and inertia by beneficiaries, as well as obstacles to private plan penetration in rural markets, will slow the pace of change in any event.

Bringing the Market into Play

If Medicare payments to beneficiaries were linked to market prices by using the enrollment-weighted competitive bids of all plans (public and private) ready to serve all comers in a given regional market, the traditional Medicare program then could and should provide drug benefits—so long as its administrators could adjust the program's other benefits and cost sharing provisions to meet market-based fiscal constraints.

"Standard politics resorts to top-down price controls and hidden benefits reductions. It won't be able to reform traditional Medicare. But market pressures and beneficiary choices will."

Beneficiaries, instead of taxpayers, would pay extra for supplemental benefits. And plans should be free to offer a wide range of supplemental benefits without having to maneuver through new bureaucratic speed bumps and guard rails.

Further fine-tuning of the Bush administration proposal should include providing full cash rebates (not just 75 percent) of the savings to seniors who choose plans that cost less than the price set through the regional competitive bidding process. Initial versions of basic drug benefits offered in all core plans should focus on stop-loss protection against high drug costs, without early dollar coverage as well.

Some secondary subsidies for lower-income seniors and beneficiaries with exceptionally high medical expenses would be far simpler to administer than continuing the perpetually elusive search for broader risk-adjusted reimbursement methods that never actually work in practice.

The essential long-term objective is to inject real-world price information into the entire Medicare program. Even its dominant fee-for-service portion will need to adjust its operations to the marketplace, instead of the other way around.

Standard politics resorts to top-down price controls and hidden benefits reductions. It won't be able to reform traditional Medicare in the decades ahead. But market pressures and beneficiary choices will, if we don't try to suppress them.

Tom Miller is director of health care policy at the Cato Institute and a contributing editor for Health Care News. *His email address is* **tmiller@cato.org.**

MISSOURI continued from page 1

Virginia and Delaware are considering a similar course of action. One opponent noted out loud at a public hearing, "that may explain why health insurance is so expensive there."

According to other detractors of Mathewson's plan, consolidation would mean the creation of a *de facto* single-payer health plan for all government employees, from municipalities to higher education to the state capitol.

University Penalized

Officials at the University of Missouri (UM) are among the Mathewson plan's most prominent opponents. UM employees would experience cost increases if their plan were folded into MCHCP.

Even without the proposed consolidation, MCHCP is already almost three times larger than the UM health care program, noted Ken Hutchinson, the university system's vice president of human resources. But MCHCP's allegedly better "purchasing power" has not meant lower premiums. "Bigger is not better for the UM system," said Hutchinson. "UM [insurance] premium rates are much lower than what the Missouri plan offers."

The UM health plan is a self-funded private-sector arrangement with United Health Care. It has consistently offered UM employees a wide variety of insurance choices while keeping premium inflation well below the national level, as well as below the premium increases experienced by MCHCP—which is again looking at double-digit increases for 2004.

According to Hutchinson, the costs to the University and its faculty, staff, and retirees would increase approximately $55 million a year if UM is included in Mathewson's consolidation arrangement. Faculty and staff members would pay nearly double their current premium rates for health insurance.

Because the health plan is an integral part of UM's overall human resources and employee benefits strategy, the Mathewson measure would force the UM Board of Curators to relinquish authority to govern its overall compensation program.

"The proposal has the effect of penalizing the University of Missouri for operating a well-conceived and efficiently managed program," Hutchinson said.

Devil in the Details

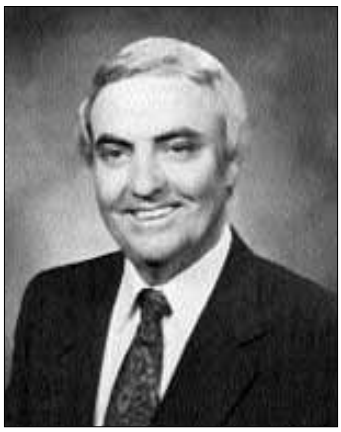
To achieve cost-efficiency goals, SB 450 would "streamline" the state's health care efforts with a new layer of bureaucracy. According to the text of the bill itself, "The goal of the Division of Community Health will be to focus the purchasing power and streamline the administration of the state's health care purchasing. The Division will have a board and a Commissioner. The Board will consist of eleven members. Two members will come from the legislature, one is the Director of the Department of Insurance, one is the Director of the Office of Administration, and the others are representatives or directors from the various groups that are assimilated under the Division of Community Health."

If passed, the bill would require the new Board to submit a report to the legislature by December 31, 2003 providing an analysis of its duties and recommendations concerning personnel or other matters. By July 1, 2004, the health care programs offered all government employees and state university employees, the Missouri Senior Rx program, and the state division of medical services would be assimilated into the new Division of Community Health.

Later in 2004, the measure begins to extend the reach of the single-payer plan beyond government employees. On December 1, the bill says, "Four new members will be added to the Board. The new members will be appointed by the Governor. One will be from the Missouri School Boards Association, one from the Missouri Community Colleges Association, and two will be representatives of small business. A subsequent report will be due from the board on 12/31/05 to update the prior report and provide any recommendations for implementation of the next phase of the program."

"[T]he costs to the University [of Missouri] and its faculty, staff, and retirees would increase approximately $55 million a year if UM is included in Mathewson's consolidation arrangement. Faculty and staff members would pay nearly double their current premium rates for health insurance."

This final phase of Mathewson's plan would allow the Division to make the new consolidated plan available to public school employees, community colleges, and all political subdivisions of the state—as well as private-sector businesses with fewer than 50 employees and uninsured citizens in the state.



Missouri State Senator James Mathewson

"Goofy Idea"

If Mathewson's measure passes, the new 11-member Board of the new Division of Community Health would be appointed. It would meet, research, analyze, discuss, and propose by December 31 the best plan for managing the state's health insurance needs.

Consolidation would not happen until July 1, 2004, and then only if the Board recommends that action. "If their report says consolidation is a goofy idea, I'll kill everything else in this bill," Mathewson pledged.

Conrad F. Meier is managing editor of Health Care News.

LICENSED TO UNZ.ORG
ELECTRONIC REPRODUCTION PROHIBITED

LEAVING continued from page 1

Fearing a death blow to Medicare, Congress responded to the doctors' pain and cancelled the scheduled fee reduction. Instead of the intended 4.4 percent cut, a 1.6 percent increase in Medicare physician payments becomes available.

"The Medicare physician payment provision in the budget bill helps shore up Medicare's foundation," said AMA President Yak D. Coble Jr., M.D. "We are pleased that both Congress and President Bush recognized that and will stop the Medicare cuts for 2003 and fix past mistakes. The bill comes just in the nick of time for Medicare patients and the physicians who care for them."

Not out of the Woods

While Medicare may have dodged a potential crisis, many doctors are still refusing to accept new Medicare patients. Some are dropping out of the Medicare program completely because of other issues.

Two of the most troubling reasons are stepped-up threats of prosecution of doctors and growing government red tape, according to the Association of American Physicians and Surgeons (AAPS). In July 1999, AAPS released the results of a survey that revealed, "Medicare regulations and a recent increased government crack down on so-called 'fraudulent' billings are actually responsible for severely restricting patients' access to medical care."

"This study is concrete documentation of the atmosphere of fear in which doctor practice today," said Jane M. Orient, M.D., executive director of the AAPS. "Money is not the issue—it's the government in the examining room. More doctors would rather treat uninsured patients, possibly for free, than risk being prosecuted as a 'Medicare cheat.'"

Case against Medicare

John A. Bennett, D.O., in a "Declaration of Independence" issued as an AAPS press release, articulately expressed reasons medical doctors are dropping out of Medicare.

"The patient-physician relationship is the foundation of the practice of medicine, yet Medicare requirements are threatening that relationship," wrote Bennett, pointing to widespread Medicare interference with medical decision-making. "Clerks and administrators are empowered to rule visits and procedures as 'medically unnecessary.'

"Medicare has also not respected the principles of patient confidentiality," he continued. "Copies of patient's records are routinely requested by Medicare administrators. Medicare has criminalized the practice of medicine, setting huge fines for minor variation from arbitrary guidelines, even going so far as to offer large bounties to patients who will suggest that their physician might be a worthy target of investigation.

"Medicare rules and regulations are so numerous and complex, and they change so frequently, that it is not possible for a reasonably informed physician to know and even understand all the rules that must be followed," Bennett wrote. "These complex rules are enforced arbitrarily, as even the enforcers cannot understand them fully."

Happiness Is Opting Out

Richard Bartucci, D.O., of Williamstown, New Jersey, agrees.

"By the early 1980s most patients over the age of 65 couldn't get any health insurance except those policies designed to supplement Medicare," he notes. "Inasmuch as all patients over the age of 65 are Medicare clients—even those who are perfectly willing and able to pay for medical treatment out of their own pockets—doctors were faced with the decision of whether to become a 'participating Medicare provider' or give up their patient's care.

"I am the kind of doctor who conceives of my profession as a duty to my patients," Bartucci says, "so I 'participated' ... with roughly the same willingness that I reach into my pocket and hand over my wallet when somebody points a gun at my belly and rumbles: 'Your money or your life.' When the federal government arbitrarily sets—and cuts—physician fees, I see no real difference between that government and a mob of Mafia goons."

Seattle, Washington neurosurgeon Michael Schlitt, M.D., quit Medicare in 1991 because he felt the U.S. government was "basically proposing Marxism as a way to provide health care for seniors." He explained that Medicare had started limiting physicians fees "in earnest" using the Resource Based Relative Value Scale (RBRVS). Built into the RBRVS was the idea that specialists should be paid relatively less than generalists.

"Implicit in this formula is the Marxist dictum, 'From each according to his ability to each according to his need,'" says Schlitt. "If I were considering rejoining today—and I certainly am not—I would be concerned about the enforcement aspect.

"As I understand what is happening at Medicare headquarters, their Office of Inspector General has been assigned a certain number of enforcement targets," continued the Seattle neurosurgeon. "Basically enforcement officers in that office have been told, 'Find x number of bad doctors every year.' If a member of that office is a little short of his target in November, I wouldn't want to be a possible target."

Chicago pain specialist Mary Jane Curran, M.D., is another physician who has dropped off the Medicare rolls. "I could not be happier that I am out of Medicare," she told *Health Care News*. "I opted out in 1998. Life is less burdensome and more productive."

Maury M. Breecher, Ph.D., M.P.H. is coauthor with Dr. Larry Francis of the forthcoming book, A Medical Doctor's Prescription to Improve the Health Care System and Your Own Personal Health.

AIDS: It's Now up to Africa's Leaders

Richard Tren

As the U.S. edges closer to war with Saddam Hussein, its global popularity seems to be ever diminishing. President George W. Bush's decision to act on the global HIV/AIDS crisis, announced in his State of the Union address, may improve his international image, but its success is far from certain.

HIV infection continues to rise in Africa, while mortality from AIDS-related illnesses is increasing alarmingly. Few African governments can be proud of their response to the epidemic. Yet some have faced this catastrophe admirably.

Ugandan President Yoweri Museveni showed bold political leadership years ago in his nation's fight against AIDS. By tackling transmission of HIV and ensuring people had access to treatment, infection rates are down 50 percent since 1992.

African governments must end widespread corruption, so that drugs donated or bought cheaply go to those who require them and are not sold to the private sector.

Weak Infrastructure

Antiretroviral drugs are needed in Africa, and pilot projects have shown that in many instances they can be taken correctly and the regimens adhered to. But such efforts require enormous investment in health infrastructure and training.

While Bush's $15 billion (of which $10 billion is new money) to fight AIDS is welcome, it will not be easy to reach the stated goal of 2 million people on antiretroviral treatment without improving infrastructure.

The few African success stories show one of the best ways of doing this is to work with the research drug firms that have developed the medicines. Nigeria recently experimented with generic antiretrovirals from India and this proved disastrous, with no more than 10 percent of those intended to get drugs actually receiving them.

"Africans are ill, unable to receive medical treatment and short of food because most African governments have kept people poor, frustrated trade, and interfered with markets."

Private Sector Needed

Generic suppliers rarely provide the necessary pharmacological back-up and advice that pharmaceutical companies offer. Despite the research pharmaceutical sector's international unpopularity, it often does more for health care in Africa than most governments. Major research drug firms have donated billions of dollars to charitable programs and fund research on medicines for diseases like malaria and tuberculosis.

Humanitarian aid is important, but continued research into new drugs is most critical. Governments can help by guarding these firms' investments through strong intellectual property rights.

Aid and humanitarian help is much needed, but decades of government-to-government aid have only left Africa poorer and more desperate than ever. To avoid misuse, the Bush plan should rely on nongovernmental and private-sector sources far more effective at delivering health care.

Colin Powell's speech to the World Economic Forum offered more hope in the longer term. Powell was clear about the need to reduce trade barriers, increase economic growth, and ensure wealth creation in poor countries.

Africans are ill, unable to receive medical treatment and short of food because most African governments have kept people poor, frustrated trade, and interfered with markets. By allowing the private sector to thrive, Africa will be able to create the wealth that can build health infrastructure.

America's billions are crucially important, but the only long-term sustainable solution is allowing Africans to get rich. And Africans won't triumph over AIDS or poverty until their leaders make a true commitment to their people.

Richard Tren is a director of the South Africa-based health NGO called Africa Fighting Malaria. This article was distributed by the London-based International Policy Network and is reprinted here with permission. Tren's email address is rtren@fighting-malaria.org.

LICENSED TO UNZ.ORG
ELECTRONIC REPRODUCTION PROHIBITED

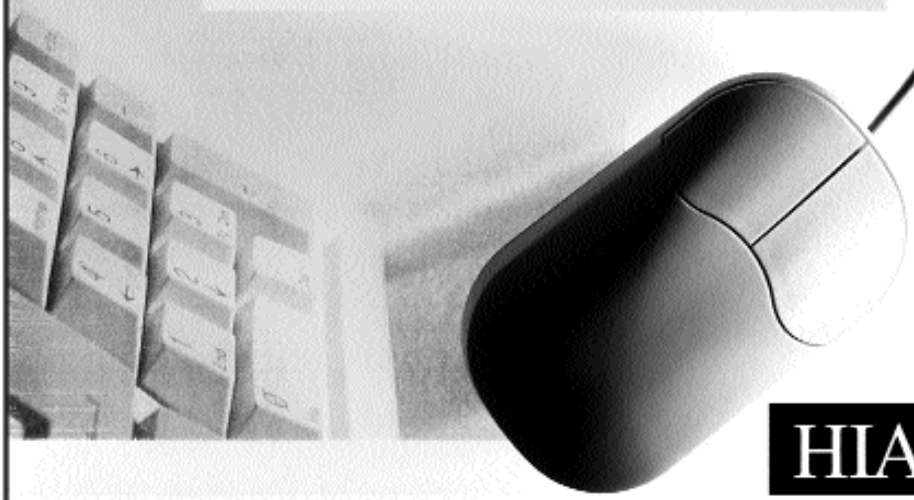
CARE MANAGEMENT
IN THE PATIENT CHOICE SPECTRUM CONFERENCE

May 13–14 ■ Sofitel Chicago O'Hare

By mid-century, health care is projected to be two-thirds of the federal budget. HIAA's conference provides a fresh look at leveraging medical management techniques and emerging technology to improve care and reduce rising health care costs.

This conference is for chief medical officers, CFOs, presidents, vice presidents, directors, and top-level managers of commercial health insurance companies, managed care plans, health maintenance organizations, preferred provider organizations, Blue Cross Blue Shield carriers, third-party administrators, reinsurers, and companies that provide supplemental, dental, disability, and long-term care insurance. Case managers, utilization managers, disease managers, and call center managers will also find this a valuable event.

Topics include evidence-based medicine, Internet tools and capabilities (eHealth), predictive modeling, disease and case management, trends in utilization management, pharmaceutical and bio-research advancements, and much more.



The conference will be held at the Sofitel Chicago O'Hare, located minutes from the Chicago O'Hare airport. Shuttle service is available. For hotel reservations, please call the hotel at 1-800-233-5959 and identify yourself as an attendee of the HIAA Care Management Conference. Special group rate is $159 single or $179 double occupancy. Reservations must be made by April 25, 2003.

HIAA® Health Insurance Association of America

www.hiaa.org

CMSA CASE MANAGEMENT SOCIETY OF AMERICA

Helping insurers and providers manage patient care while reducing costs

LICENSED TO UNZ.ORG
ELECTRONIC REPRODUCTION PROHIBITED

Obese Kids Re-Plead Their Case

New attack says chemicals turn McDonald's products into "junk food"

Conrad F. Meier

Lawyers for two obese New York teenagers and their siblings filed an amended complaint to replace the original suit dismissed by Judge Robert Sweet in the U.S. District Court of New York. Physicians and scientists at the American Council on Science and Health (ACSH) called the second filing against McDonald's Corporation "without scientific merit."

The new complaint, filed February 19, says the plaintiffs ate McDonald's foods several days a week, becoming obese and ruining their health. The suit claims McDonald's products are non-nutritious because, in part, many of the products contain preservatives and other "chemicals." The lawsuit implies natural, unprocessed foods are chemical-free and thus "healthier."

According to Dr. Elizabeth Whelan, ACSH president, the claim is without merit. "All foods are chemicals," Whelan said in a statement issued after the suit was filed, "we're just not routinely provided with the long list of natural chemicals in the meals we eat every day.

"Potatoes, for example, naturally contain over 150 chemicals, including traces of arsenic and solanine—chemicals that are safe in low doses but harmful at high ones. Coffee, for another, naturally contains methanol, acetaldehyde, isoprene and dimethyl sulfide—enough polysyllabic items to scare any chemophobic citizen."

Not only are chemicals such as preservatives not harmful, note ACSH scientists, but they actually help *protect* health by preventing spoilage. All such chemicals are approved for use in human food by the Food and Drug Administration (FDA).

"Not only are chemicals such as preservatives not harmful, note ACSH scientists, but they actually help *protect* health by preventing spoilage."

"A Choice Freely Made"

On a motion to dismiss filed by McDonald's, Judge Robert Sweet dismissed the original complaint in *Pelman v. McDonald's* in its entirety on January 22. In his 65-page opinion, Sweet noted,

> As long as a consumer exercises free choice with appropriate knowledge, liability for negligence will not attach to a manufacturer. It is only when that free choice becomes but a chimera—for instance, by the masking of information necessary to make the choice, such as the knowledge that eating McDonald's with a certain frequency would irrefragably cause harm—that manufacturers should be held accountable. Plaintiffs have failed to allege in the Complaint that their decisions to eat at McDonald's several times a week were anything but a choice freely made and which now may not be pinned on McDonald's.

Sweet, however, also identified in his opinion which of the plaintiffs' arguments he felt was strongest, noting

> If plaintiffs were able to flesh out this argument [that the chemical composition of McDonald's products is not common knowledge] in an amended complaint, it may establish that the dangers of McDonald's products were not commonly well known and thus that McDonald's had a duty toward its customers.

As is common when a defendant's motion to dismiss is granted, Sweet granted plaintiffs leave to replead nearly all of their claims, requiring only that the amended complaint be filed within 30 days of his opinion.

The amended complaint took advantage of Sweet's encouragement on the chemical composition argument. Dr. Ruth Kava, ACSH nutrition director, says that encouragement was "misleading, in that it falsely implies that consuming processed foods with chemicals can cause obesity." She notes the amended complaint specifically lists the chemical ingredients in Chicken McNuggets, "implying the ingredients were unfamiliar and therefore were somehow unhealthful and caused obesity.

"All foods are composed of chemicals," Kava reiterated. "It is an excess of calories consumed relative to calories expended that causes weight gain."

Conrad F. Meier is managing editor of Health Care News.

For more information…

Court documents related to *Pelman v. McDonald's* are available through *PolicyBot*. Point your Web browser to **http://www.heartland.org**, click on the *PolicyBot* button, and search for document #**11750** for the full text of Judge Robert Sweet's 65-page opinion dismissing the original complaint, and document #**11749** for the 28-page amended complaint.

SMALLPOX continued from page 1

Risky Business

An official at the Centers for Disease Control and Prevention (CDC) explained to *Health Care News* the vaccine is risky. It is made with a live virus that can infect the body. Experts estimate between 15 and 50 people of every 1 million vaccinated for the first time will face life-threatening complications, and one or two will die.

Thomas Mack, MD, MPH, professor of preventive medicine at the Keck School of Medicine, University of Southern California at Los Angeles, recently told Medscape, "Vaccinating large numbers of staff identified by the hospitals as well as the general public is a mistake, because the deaths from vaccine complications will outweigh any limited increase in protection. Mass vaccination will guarantee a few deaths."

Katharine Eaves, a nursing supervisor from Los Angeles, told the *Washington Post*, "There is a period after vaccination where a person is infectious and should not be at work or caring for patients. That's two to three weeks. I can't have my staff at home for that long."

The *Post* also quoted Robert Scates, a representative of the Chicago firefighters union, as saying, "I'm not going to take [the vaccine]. I know too much about it. I was born in 1946, so I had the smallpox vaccine when I was growing up. As far as I'm concerned, I've already had it."

The last known U.S. smallpox case was in 1949, and routine vaccinations against the disease ended in the United States in 1972. All stocks of the virus were supposedly destroyed, except for samples in special labs in Atlanta, Georgia and Moscow. Experts suspect some of the Russian stock might be in the hands of hostile nations, including Iraq.

With the United States moving toward war against Iraq, Bush started the vaccination program last December. He ordered inoculations for the military, and the Pentagon says it is reaching its goal of inoculating 500,000 military personnel. Fewer than 10 soldiers have been reported to suffer serious reactions. All have recovered.

Practical Questions

The vaccine's risk has caused some to ask who will compensate those hurt by the vaccine for lost wages and medical expenses.

People hurt by other vaccines can tap into a federal compensation fund, but the smallpox vaccine is not covered. Some health care unions have urged their members to refuse the vaccine until the government can guarantee compensation for anybody injured by it. Some would be eligible for workers compensation, but those benefits often are skimpy.

"If everything is done perfectly, without any negligence, some percentage of people given the vaccine will be injured by it," Louisiana State University's Dr. Katherine C. Rathbun told the *New York Times*. "It's a dangerous vaccine and they will not be compensated under the law."

HHS Secretary Thompson has said he is working on a federal compensation program, but he has yet to present one.

Compensation for injury is not the only issue raised by opponents of the vaccine program. Hospital administrators worry vaccinated health care professionals could accidentally spread the virus used in the vaccine to patients, many of whom are weak and particularly susceptible to injury. Many administrators are not convinced the risk of the disease is greater than the risk of the vaccine.

One hospital to decline participation is Grady Hospital in Atlanta, Georgia. Carlos del Rio, chief of medicine at Grady, explains: "You have a disease that hasn't been seen anywhere in the world in nearly 30 years. The risk of the vaccine is higher than the risk of us having a case of smallpox."

CDC Director Julie Gerberding responds by saying she has been in meetings where intelligence information was shared, and she knows a real risk exists. So far, many remain unpersuaded.

In an Associated Press interview, Dr. M. Ward Hinds, health officer for the Seattle-area Snohomish Health District, explained, "Hospitals are deciding the risk is so low as to be immeasurable." In his five-county region, just three of eight hospitals will offer the vaccine to their workers.

The unwillingness of first responders to participate in the vaccination program raises doubts about whether federal officials will move to the next stage of the plan, which targets as many as 10 million other health care workers, firefighters, police, and other emergency early response personnel. In December, federal officials said the vaccination project would move seamlessly from the first to the second stages. Today, some are questioning whether it is even needed.

Conrad F. Meier is managing editor of Health Care News.

I believe in freedom. What do YOU believe in?

Colorful, high-quality, extra durable bumper stickers look great on file cabinets, doors, windows, and folders as well as cars. A great present for friends, coworkers, relatives, and neighbors. Impress your friends! Irritate your enemies! Place your order today!

$1.49 each	$37.50 for 50
$9.99 for 10	$59.99 for 100

To order, visit www.heartland.org or call The Heartland Institute at 312.377.4000.
Or, send a check or money order to The Heartland Institute
19 South LaSalle Street #903 Chicago, IL 60603

LICENSED TO UNZ.ORG
ELECTRONIC REPRODUCTION PROHIBITED

From Welfare Reform to Medicaid Reform

Joe Moser

A study published in February 2003 by the Kaiser Commission on Medicaid and the Uninsured found the uninsured received $35 billion in health care for which they did not pay in 2001. Of this care, $30.6 billion was paid with government funds in addition to the cost of Medicaid.

Health care for the uninsured represents only a small fraction of government spending on health care. The government spent a total of $647 billion on health care in 2001, including Medicare, Medicaid, and other public programs.

Medicaid alone cost $224 billion in 2001 and is expected to cost $277 billion this year, according to the Centers for Medicare and Medicaid Services, more than $1,000 for every man, woman, and child in the country.

The strain on state and federal health care budgets is significant and getting worse. Escalating Medicaid costs are largely responsible for state budget deficits so large that most legislatures are considering income or sales tax increases or threatening cutbacks in other public programs like education and highways.

"Most state programs are over-extended, offering more benefits to more people than is sustainable during times of recession."

How We Got into this Mess

The boom economy of the mid 1990s and beyond made it possible for states to expand the reach of their Medicaid programs to populations not ordinarily covered by the program. Most state programs are over-extended, offering more benefits to more people than is sustainable during times of recession. As more workers find themselves laid off or working for an employer that can't afford to provide health coverage, many are enrolling in Medicaid.

A survey conducted last year by Health Management Associates for the Kaiser Commission on Medicaid and the Uninsured showed a Medicaid enrollment increase of 8.6 percent in 2002. This is slightly less than the 9.7 percent enrollment increase in 2001, but both are substantial increases over previous years. (See Figure 1.)

The states themselves listed enrollment increases as the number two cause of program spending increases behind pharmacy costs, according to the Kaiser survey. (See Figure 2.) Eighteen states said enrollment increases were the number one factor.

The increased enrollment growth was due in part to increases in eligibility limits. In some states, individuals with incomes three times the federal poverty limit (FPL) are eligible for Medicaid. For example, children can be enrolled in Missouri Medicaid's Managed Care Plus program if their families make less than 300 percent of the FPL, or $55,200 per year for a typical family of four. Children in Vermont qualify for Medicaid if their family income is below 225 percent of the FPL, and uninsured adults qualify if their income is no more than 185 percent of poverty.

The same thing is true for the State Children's Health Insurance Program (SCHIP). Originally designed to help children who "fall between the cracks" because their families don't have private insurance but also have incomes too high for Medicaid, some states have now extended coverage to the *parents* of these children. Colorado, Illinois, Maryland, New Jersey, Rhode Island, and Wisconsin have all extended their SCHIP programs, although New Jersey has stopped accepting new parents. Arizona uses unspent SCHIP funds to cover uninsured low-income adults *without* children.

Cut the Strings

What can be done to address the unsustainable expansion of state Medicaid programs? President Bush released in January the details of a plan that would offer states the flexibility to modernize their Medicaid programs for optional populations in exchange for some up-front federal assistance to get the changes off the ground.

Essentially, $3.25 billion would go to states accepting the offer for fiscal year 2004, with an additional $12.7 billion over the next seven years. States would be allowed to alter their programs for optional eligibility groups and optional services without first getting a waiver from the Department of Health and Human Services.

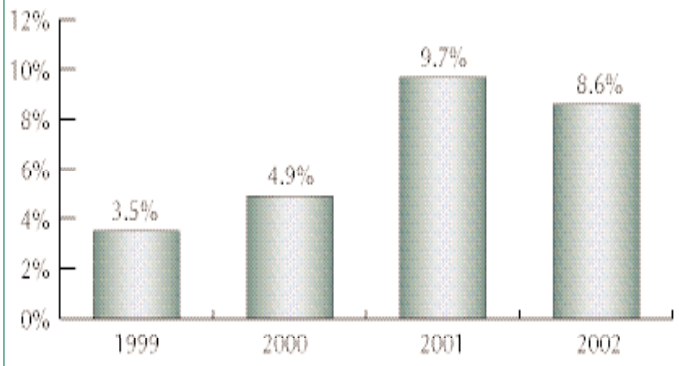
The Bush proposal would cut some of the strings attached to the federal bureaucracy and give states more flexibility with their Medicaid programs to contain costs. Like the successful federal welfare reform adopted in 1996, the Bush Medicaid proposal is built on the principle of engaging people in making responsible choices.

In most states, Medicaid beneficiaries would probably be expected to bear more of the cost of the services they use, giving them a better sense of the value of the care they receive. Getting beneficiaries more involved in their health care decision-making will also give this population increased choice of doctors, hospitals, and health coverage.

Critics of the Bush plan are mostly skeptical of the administration's intentions. They worry the proposal is aimed at limiting federal spending on health care for the low-income. Worse yet, they fear the plan might prove as successful as welfare reform.

Medicaid Enrollment Increases

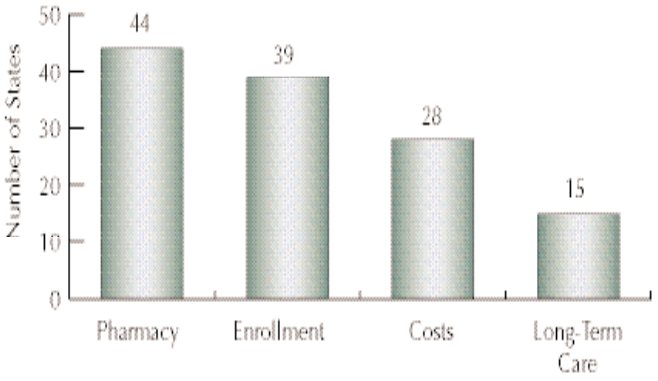
Figure 1



Source: Kaiser Commission on Medicaid and the Insured survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, June 2002

Factors States Reported as Among the "Top Three" Increasing Medicaid Spending

Figure 2



Source: Kaiser Commission on Medicaid and the Insured survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, June 2002

In defense of reforming Medicaid, a February 10, 2003 *Wall Street Journal* editorial stated, "The same folks who inaccurately predicted the 1996 welfare reforms would leave indigent masses gutter-bound are now insisting that states will use this flexibility to toss people off the rolls. But that's not in their best interests. These people will receive health care one way or another ..."

Using Defined Contributions

One option for reforming existing programs is to implement a voucher system using current Medicaid dollars. States could take existing Medicaid dollars and give each beneficiary his or her share in the form of a voucher for the purchase of private insurance from a menu of state-approved private-sector health plans, including Medical Savings Accounts.

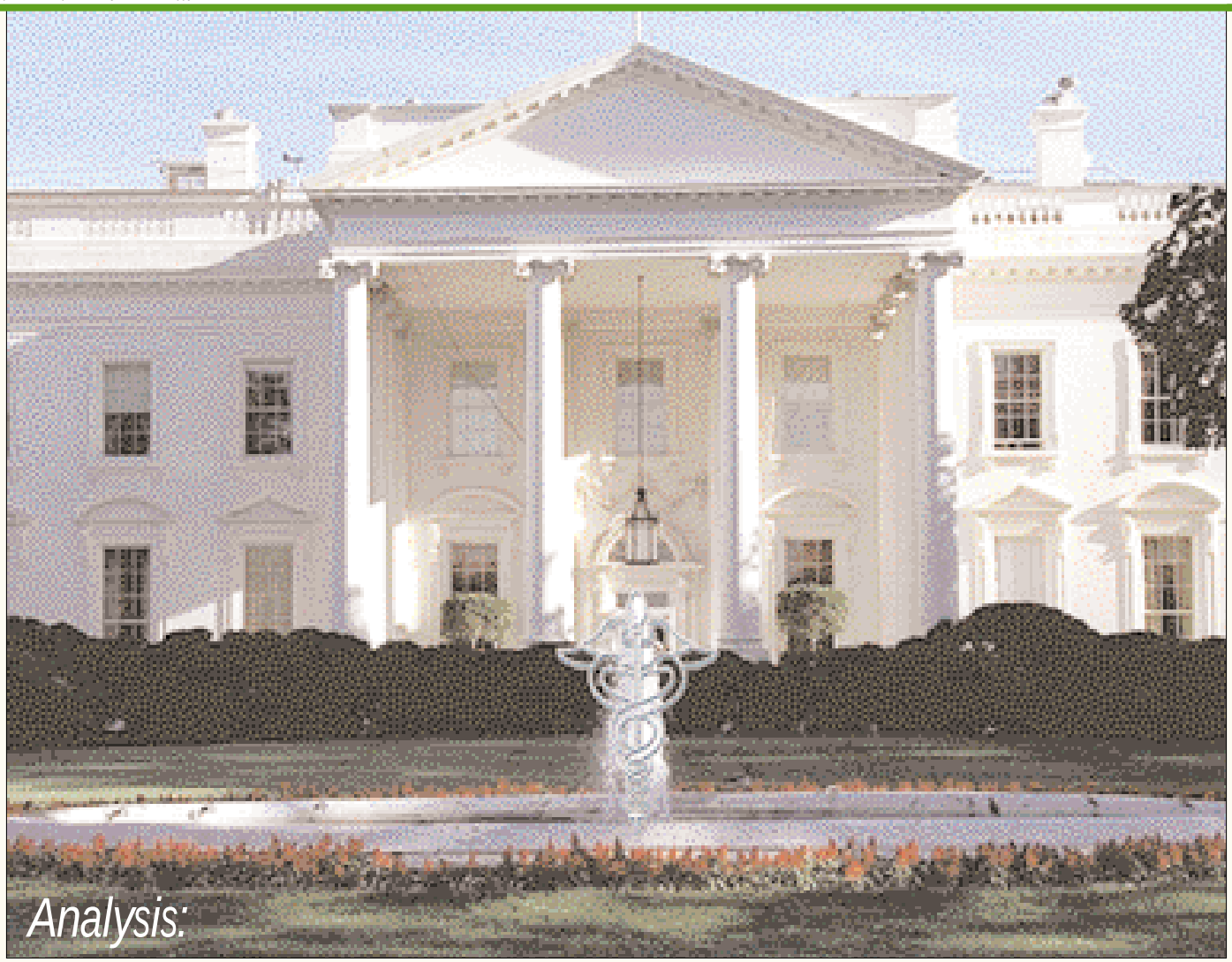
Using vouchers as a vehicle for Medicaid reform accomplishes two things: It caps state expenditures at a defined-contribution amount, instead of the current, more open-ended and costly defined benefit; and it gives beneficiaries the ability to purchase coverage better tailored to their needs.

The ability of Medicaid beneficiaries to make choices concerning their own health care has been proven by the success of the Medicaid Cash and Counseling program. The program allows certain elderly and disabled beneficiaries to purchase their home health care and other community-based services with cash allowances. Beneficiaries hire and fire people who provide services, including their own family members. Cash and Counseling has nearly a 100 percent beneficiary satisfaction rate in Arkansas, Florida, and New Jersey, the first states to try the program.

Reforming Medicaid along these lines would give states the flexibility to control expenditures while improving satisfaction levels among beneficiaries in the program. Giving people the opportunity and incentives to improve their economic condition can work for health care as well as it did for welfare reform in the 1990s.

Joe Moser is a health policy analyst at the Galen Institute, a not-for-profit public policy research organization based in Alexandria, Virginia. The views expressed here are the opinions of the author and do not necessarily reflect the views of the Galen Institute.

LICENSED TO UNZ.ORG
ELECTRONIC REPRODUCTION PROHIBITED



Analysis:

Where Do They Stand?

While some Democratic Presidential hopefuls have staked out positions on health care reform, others remain tight-lipped

Conrad F. Meier

Health care issues—especially access to affordable health insurance—will likely play a larger role in the 2004 Presidential race than in 2000, particularly if proposals from former Vermont Governor Howard Dean and Missouri Congressman Richard Gephardt are taken seriously. Addressing the uninsured could be a centerpiece of the Democratic strategy for recapturing the White House.

Kenneth Thorpe, a former Clinton administration official and an Emory University professor, recently told the *Los Angeles Times*, "To me, what's exciting is that the universal coverage debate is back on the national agenda. That in itself is huge."

The *Los Angeles Times* also reported universal coverage plans are a response to increasing health insurance costs and narrowing access to care—factors that inspired former President Clinton's doomed crusade for universal coverage. To avoid the backlash Clinton's plans received, new Democratic proposals are accompanied by claims they will be administratively simple, preserve consumer choice, and won't disrupt the existing health system.

In his fiscal year 2004 budget blueprint, President Bush proposed spending $89 billion over 10 years to give Americans tax credits to purchase health insurance. Eligible families with two or more children and annual incomes below $25,000 could receive up to $3,000 in credits to cover as much as 90 percent of the costs of purchasing health insurance.

Stuart Butler, director of domestic policy studies for The Heritage Foundation, told the *Los Angeles Times*, "The irony is that you've got liberals saying we've got to let employers, even if they are lousy employers, make all the decisions for you and your family, and here are the conservatives saying, 'Let's let ordinary people decide what's best for themselves.'"

CAROL MOSELY BRAUN
Former U.S. Senator, Illinois

Braun has not yet addressed health care as an issue for her campaign, nor was it a key issue during her Senate term.

Indeed, Braun's closest encounter with health care policy may be the investigation launched against her for Medicaid fraud. The *Chicago Tribune* reported in September 1992 that Braun was investigated for taking a $28,750 check from her mother so Medicaid would continue paying for her mother's nursing home care. The Illinois Department of Public Aid investigated the matter while Braun was serving as Recorder of Deeds for Cook County, Illinois. Braun eventually re-paid $15,239.

The *Chicago Tribune* has called her public service a "squandered" and "failed" opportunity to represent Illinois. "She has given Illinois citizens a stream of reasons to question her judgment." She has been plagued by scandal, including misappropriation of an inheri-

LICENSED TO UNZ.ORG
ELECTRONIC REPRODUCTION PROHIBITED

tance, allowing sexual harassment of workers, and misuse of campaign funds. The Internal Revenue Service twice sought to investigate her finances, but the Clinton Justice Department denied both requests.

Braun's voting record is solidly liberal, including her vote for the largest tax increase in U.S. history; a vote to increase taxes on senior citizens' Social Security benefits; and numerous "yea" votes for federal budgets balanced using the Social Security surplus.

HOWARD DEAN
Former Governor, Vermont

The centerpiece of Dean's Presidential platform is universal health care. He is on record as saying he would repeal most of President George W. Bush's tax cut in order to fund a national health insurance program.

According to David S. Broder, writing in the July 12, 2002 edition of *The Washington Post*, "Dean not only advocates universal health insurance but also tells audiences that Vermont already has moved in that direction. How to pay for this? Simple, says Dean. Roll back virtually all of President Bush's tax cut of 2001."

C. David Kotok, writing in the October 9 *Omaha World-Herald*, notes, "In his appearances, Howard Dean champions universal health care patched together with a government-supported program to guarantee health insurance for the young, prescription benefits for the elderly, and insurance support for small-business employees. 'This is not a big government plan,' Dean said. 'Insurance companies should like this plan.'"

Dean's proposal, which does not yet have a cost estimate, would extend Medicaid to all U.S. residents under age 23 and offer subsidies to small employers to encourage them to offer their employees health insurance.

In the December 18 issue of the *Rutland* (Vermont) *Herald*, John McClaughry, president of the Ethan Allen Institute, accused Dean of balancing the state budget on the backs of citizens by "robbing other state funds, increasing local share property taxes, and levying an unlegislated tax on health insurance paid by individuals, small businesses, and self-insured companies."

JOHN EDWARDS
U.S. Senator, North Carolina

According to the May 8, 2002 edition of CNN's *Inside Politics*, "After Edwards' lackluster performance on NBC's *Meet The Press*, many Democrats felt he may not be ready for prime time." According to Marc Rotterman, writing in the December 8 issue of the *Raleigh News and Observer*, "Edwards has become a captive of the trial lawyers and the left-wing special interests in Washington. He has lost touch with the average American."

Wall Street Journal editors note more than four of every five dollars raised by Edwards for his PAC, New American Optimists, has come from personal injury trial lawyers. They say Edwards caters to that special interest group by fighting tort reform in Congress and facilitating the initiation of lucrative lawsuits in the private sector.

Edwards is unpopular among health care providers because he supports unlimited awards in medical malpractice suits, according to a June 24, 2001 *Chicago Tribune* article by Jill Zuckman. Senator Lauch Faircloth (R-North Carolina) told CNN's Jonathan Karl in November 1998, "He is absolutely a clone of Bill Clinton."

Edwards has not articulated a formal position on health care reform, but actions often speak louder than words. Between 1999 and 2002, according to a Congressional Quarterly vote comparison (**www.cq.com**), Edwards voted with Senator Edward Kennedy (D-Massachusetts) 90 percent of the time and Senator Hillary Clinton (D-New York) 89 percent of the time.

RICHARD GEPHARDT
U.S. Representative, Missouri

Gephardt, according to an article by Dan Balz in the January 20, 2003 issue of *The Washington Post*, is an ineffective leader, traditional liberal Democrat, and "keeper of the liberal flame for organized labor and party activists." But Iowa Governor Tom Vilsack (D) warns "Gephardt's union support is not a sure thing," and Balz quotes Iowa resident Libby Slappey as saying, "Gephardt's not even on our radar screen."

"In announcing his Presidential campaign, Gephardt offered a sweeping plan that would ... require all employers to offer health insurance ..."

In announcing his Presidential campaign, Gephardt offered a sweeping plan that would require all employers to offer health insurance; give employers a tax credit that would cover as much as 65 percent of their costs to do so; allow uninsured people aged 55 and older to buy into Medicare; allow parents to enroll in CHIP programs aimed specifically at uninsured children; and offer subsidies to help unemployed people retain their former health coverage through COBRA.

The Gephardt campaign has not worked up a cost estimate for his proposal, but an aide told *Health Care News* he would fund it by repealing most of the 2001 Bush tax cut and by using the increased tax revenue he expects to come from businesses expanding as a result of reduced health benefits costs.

JOHN KERRY
U.S. Senator, Massachusetts

According to the Roll Call Key Votes summarized by Congressional Quarterly at **http://www.cq.com**, Kerry voted in lockstep with Massachusetts Senator Kennedy in each of 10 years between 1985 and 2001. Over the course of his Congressional career, Kerry has sided with Kennedy 94 percent of the time when key votes were taken on Kennedy's favorite cause: a government-run national health care plan.

Kerry has supported the Medicare Reform Act, the Patient Bill of Rights, the State Children's Health Insurance Plan (SCHIP), the Nurse Reinvestment Act, the Women's Health Equity Act, the Family and Medical Leave Act, and the Health Insurance Portability and Accountability Act (HIPAA).

Each of those measures imposes significant benefit and procedural mandates on health care providers and the health insurance industry. Research has shown those mandates have increased the overall cost of health care and health insurance, which in turn have led uninsurance rates to climb.

A *U.S. Newswire* report dated February 5, 2003 quotes Kerry as saying, "We have spent more than a decade putting patient protections into place, protections that the Bush administration is forfeiting for a bargain basement solution for small businesses desiring affordable health.

"The challenge, " Kerry notes, "is to develop more effective pooling mechanisms that give small businesses more leverage in the health insurance market."

If Kerry's support for "pooling mechanisms" extends to association health care plans, he should come right out and say he supports the position President Bush has staked out. If he thinks a national health care plan is the best way to offer small businesses a "pooling mechanism," Kerry should say that, too.

Kennedy has repeatedly balked when asked if he supports Kerry's bid for the nomination. But on January 22, 2003, the *Boston Globe* reported Kennedy "not only backed his junior colleague, but expected him to win the White House."

JOSEPH LIEBERMAN
U.S. Senator, Connecticut

Of all the potential candidates, according to Laurence D. Cohen's article in the November 3, 2002 issue of *The Hartford Courant*, Senator Lieberman "is so inventive, has been so creative, and has been so gymnastic in its many shapes and forms, that only he can even begin to explain it. Many politicians look a bit oily, a bit uncomfortable moving across and around the political spectrum, but our Joe looks as comfortable as if he's merely changing clothes."

When Al Gore chose him as his running mate for the 2000 election, Lieberman ranked as one of the more conservative Democrats in the Senate. But as a Vice Presidential hopeful, he ran away from his conservative record on many issues, including approaches to expanding health care access and lowering insurance premium costs.

In hundreds of media interviews, Lieberman has never articulated a clear position on health care reform. The media appears to have avoided asking him the tough health care reform questions, and Lieberman himself remains conspicuously silent on the issue.

Even his Web site (**http://lieberman.senate.gov**) is devoid of any statement of his health care reform philosophy. The best one gets is "he works to expand quality and affordable healthcare to all Americans and safeguard Medicare and Social Security for future generations."

Just how President Lieberman would "expand quality and affordable healthcare" is a mystery.

Conrad F. Meier is managing editor of Health Care News.

LICENSED TO UNZ.ORG
ELECTRONIC REPRODUCTION PROHIBITED

Scandlen AT LARGE BY GREG SCANDLEN

Maryland and HRAs

I recently testified on Health Reimbursement Arrangements before the Maryland Senate Finance Committee.

Maryland is unique in having a "Health Care Access Commission" that defines what benefits will be allowed to be offered in the small group market. The powers-that-be in Maryland (including the couple of major insurers that control most of the market) are quite happy with this arrangement. Publicly they argue that having standardized benefit plans is good for consumers because it makes it easier to comparison-shop among plans. In fact, it impedes competition and innovation, so the major players can continue dominating the market without having to work very hard.

A few years ago the Commission decided to allow MSAs to be sold in Maryland, but added so many requirements to the already-complicated federal rules that few if any have ever been sold in the state. The legislation I was testifying on would have required the Commission to allow small employers to establish Health Reimbursement Arrangements. There were quite a few misconceptions among the Senators. They seemed to assume, for example, an HRA must involve a high-deductible insurance plan.

Source: **http://www.galen.org/news/021303a.html**

Labor and Health Benefits

Referring to the coming round of labor negotiations, where health care will be at the very top of the agenda, David Stires writes in *Fortune* magazine, "You don't need a crystal ball to see that that is a fight waiting to happen." The tone was set by the two-day walkout by General Electric workers and the earlier 44-day strike at Hershey Foods.

The GE workers did not want to bear an additional $200 to $400 per year in out-of-pocket costs, and the Hershey workers agreed to take lower pay increases to offset increased health care costs.

The article says corporations, especially in manufacturing, are reaching a breaking point. Health care costs are soaring, rising by 44 percent since 1999 at GE. SBC Communications is even worse off, with health costs jumping by almost 50 percent since 1999, requiring a total outlay of $2.5 billion for 343,000 active and retired employees—$7,829 per person. The Big Three automakers have total health care liabilities of $92 billion—50 percent greater than their combined market capitalization of $66 billion.

Strikes are likely and could kill off the economic recovery. The *Fortune* article notes the West Coast dock strike last year "was the single biggest influence on the fourth quarter's sharp drop in national output," costing the economy $2 billion a day.

There isn't much optimism in the article. While GE's senior vice president of human resources is quoted as saying the company was passing on just 10 percent of its health care increases, the president of the union, Edward Fire, said "we'll fight to the bitter end" if the company tries to get workers to pay more of their health care spending.

Source: **http://www.fortune.com/fortune/articles/0,15114,423756,00.html**

Overutilization Overstated

With union dynamics like that, consumer-driven health care seems an awfully thin reed to pin our hopes on. Theodore Marmor and Kip Sullivan argue in the *St. Paul Pioneer Press* that the whole premise is wrong. They see a giant conspiracy by corporate America to mislead the public into thinking health care inflation is the fault of over-insured patients. "There is no credible evidence that Americans received a lot more medical care in the past few years," they write.

The real culprit, they claim, is "the market power of insurers, drug manufacturers, hospitals and other suppliers of medical services." They argue underuse is every bit as prevalent as overuse. "Advocates of medical savings accounts ... know they have no solution for underuse and that their practices will almost surely aggravate it."

Source: **http://www.twincities.com/mld/ pioneerpress/news/opinion/5216693.htm**

Third-Party Rationing

The *Orange County Register* points out one of the reasons costs rise in the health care industry faster than in other sectors of the economy is because health care is more heavily regulated than other sectors. "The best way to arrest the cost increases in health care, or even reverse them, would be to reduce the role of government and increase the role of the private, voluntary sector." It adds, "When third parties pay and recipients perceive services as 'free,' the tendency is to demand more than is really needed, which drives up prices or induces rationing."

Source: **http://www2.ocregister.com**. *Search Commentary.*

Consumerism Needed

Michael Prince writes in *Business Insurance*, "Cost-shifting is only a temporary solution." What is really needed, he notes, is "a fundamental change in employees' health care mindset."

The article quotes Jack Mollen of EMC Corp. as saying, "We can never solve the 15 percent compounded growth problem without focusing on the long term." The article goes on to say a successful long-term approach "involves instilling a consumer mentality," including cost awareness and better information.

Keith Peden of Raytheon said 3,000 employees have signed up for Definity's consumer-driven plan. He reports no adverse selection. At Coors Brewing, 14 percent of employees signed up for the plan when it was first offered. But Mollen added consumerism does not have to mean adding a consumer-driven plan. "Consumerism is getting the employee to be an effective decision-maker. It's about making the right choices."

Source: **http://www.businessinsurance.com/cgi-bin/article.pl?articleId= 12351&a=a&bt=cost-shifting**

Milwaukee Employers Consider Fee Schedules

Employers in Milwaukee are looking at reinstating fee-schedule payments, according to Joe Manning in the *Journal Sentinel*. "The idea is high on the agenda of the Business Health Care Group of Southeast Wisconsin," which includes most of the area's larger employers. The group has employed Mercer Consulting to study whether the idea could be part of the solution.

Humana's Larry Rambo says his company also has been looking at the feasibility of a fee-schedule product. And Richard Blomquist has been looking at price variations in the area and setting up a fee-schedule program under Blomquist Benefits. He has found hospitals charging from $2,736 to $6,268 for vaginal childbirth. His fee schedule would pay slightly more than $3,800. Fees for a colonoscopy range from $743 to $2,552 and for a coronary artery bypass from $21,250 to $43,567. The article raises the concern about higher payments for more complicated situations, and the need for patients to know about quality and safety along with prices.

Source: **http://www.jsonline.com/bym/News/feb03/118760.asp**

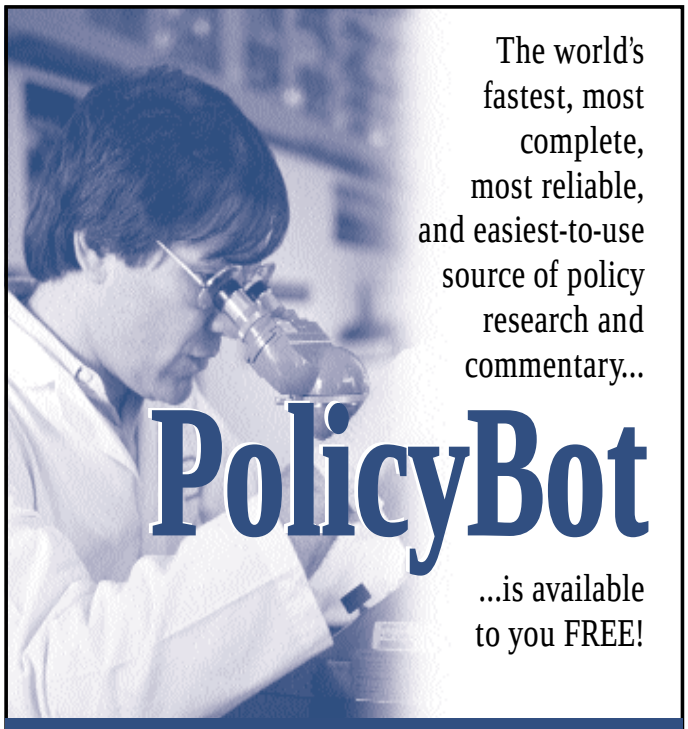
Association Health Plans Get Senate Help

Kent Hoover reports "Momentum Grows for Association Health Plans" (AHP) in several of the local business journals. The hook is a hearing chaired by Senator Olympia Snowe (R-Maine) in her new role as head of the Senate Small Business and Entrepreneurship Committee. The hearing heard from hard-pressed business owners and led Snowe to conclude, "Let there be no doubt, there will be cost savings [if AHPs are enacted]."

Also testifying in favor of AHPs were Secretary of Labor Elaine Chao and Small Business Administration's Hector Barreto. The article says Snowe has the moderate credentials to appeal to Democrats, and the AHP drive is also helped by the election to the Senate of Jim Talent (R-Missouri), an ardent proponent when he was in the House. Opposing AHPs are the Blue Cross Blue Shield Association and state insurance commissioners.

Source: **http://tampabay.bizjournals.com/ tampabay/stories/2003/02/17/story8.html**

Greg Scandlen is director of the Galen Institute's Center for Consumer Driven Health Care and assistant editor of Health Care News. *Please send all comments/questions directly to Scandlen at* **gmscan@aol.com**


The world's fastest, most complete, most reliable, and easiest-to-use source of policy research and commentary...
PolicyBot
...is available to you FREE!

PolicyBot™ gives you free, instant access to the complete texts of more than 11,000 studies, reports, articles, and other documents on today's hottest public policy issues.

PolicyBot™
The information you need, when you need it.
@
www.heartland.org

LICENSED TO UNZ.ORG
ELECTRONIC REPRODUCTION PROHIBITED

Medical Malpractice Reform Critical for Seniors Health Care

Charles W. Jarvis, J.D.

Senior citizens know all too well that doctors are fleeing from the medical profession. Increasing bureaucracy and paperwork, excessive medical litigation, reduced payments from Medicare, and skyrocketing liability insurance costs are forcing doctors to change specialties, move their practices, or leave health care altogether. The broken medical litigation system rewards only trial lawyers and leaves patients with higher costs, restricted medical care, and difficulties finding doctors.

AMA: Eighteen States in Crisis

The American Medical Association recently added seven new states, bringing the total to 18 states "in crisis" because skyrocketing insurance premiums are driving doctors out. Most recently, doctors in New Jersey and Florida held a work slow-down to highlight the problem.

Mississippi is expected to lose 20 percent of its doctors. Las Vegas, Nevada is expected to lose 10 percent of its doctors. In one Pennsylvania county, 65 percent of physicians surveyed indicated they are considering moving their practice to another state. Other states in crisis include Florida, Illinois, New York, North Carolina, Pennsylvania, and West Virginia.

Hospitals are literally being shut down. Last July, one Nevada trauma center closed for 10 days because surgeons could not afford their insurance premiums, the price of which ranged from $40,000 to $200,000. The nearest equivalent trauma center is five hours away, seriously threatening the lives of patients needing emergency care.

Patients Suffer Most

The problem is worsening, with more states facing crises as each month goes by. But those who suffer most from skyrocketing medical litigation are the patients.

Patients are suffering in all walks of life, young and old, black and white, in urban areas and rural areas. One survey revealed more than 76 percent of doctors are concerned that malpractice litigation hurts their ability to provide quality care to their patients.

Patients are being subjected to additional, and often unnecessary, testing simply because doctors are threatened by possible lawsuits at every turn. Seventy-nine percent of doctors said they ordered more tests than they normally would have, for fear of lawsuits. Fifty-one percent recommended more invasive procedures (such as biopsies) to confirm diagnoses than they otherwise would have. Surgeons are fearful of performing surgery on riskier patients, such as seniors. This constant threat of lawsuits discourages medical professionals from taking innovative new efforts to treat medical problems.

Seniors Support Reform

United Seniors Association's 2002 Post-Election Voter Survey, conducted by the Winston Group, showed overwhelming support for malpractice reform. Seventy-five percent of all voters and 76 percent of voters over the age of 65 want lawsuit judgments limited and excessive litigation ended.

"The broken medical litigation system rewards only trial lawyers and leaves patients with higher costs, restricted medical care, and difficulties finding doctors."

AARP's lack of endorsement for H.R. 5, The HEALTH Act, is in direct opposition to its members' views on malpractice litigation reform. Once again, AARP has shown it values its liberal allies and big-government political agenda more than it values its own members.

The broken legal system is raising Americans' health care costs through higher out-of-pocket payments, insurance premiums, and federal taxes. Americans could save as much as $100 billion a year immediately in private and federal health care costs with reasonable damage recovery.

Last year alone, insurance premiums in many states increased by more than 20 percent on average, and more than 75 percent for specialties in some states. These soaring insurance premiums for doctors get passed through to patients in the form of higher health care costs and higher taxes. This badly broken system of litigation serves the interest of specialized trial lawyers, *not patients.* A large number of plaintiffs get nothing from their lawsuits.

Fixing the medical liability crisis will mean more money for improved health care coverage options and prescription drug coverage. The fastest and most cost-effective way to improve patient access to care, quality of health care, and reduce costs for patients is for Congress to reform the medical liability system to guarantee reasonable non-economic damages and discourage frivolous lawsuits. The House and Senate should follow President Bush's leadership and must stand up for patients—not for lawyers and the ridiculously high costs they bring to our health care system.

Charles W. Jarvis, J.D. is chairman and chief executive of United Seniors Association, a Washington, DC-based group uniting the generations for tax freedom, health care freedom, and retirement and investment freedom for today's seniors and future retirees. Jarvis can be reached at **www.unitedseniors.org** *or* **USA@unitedseniors.org**.

Art Linkletter
Honorary Chairman

Uniting the Generations for America's Future

Join United Seniors Association's fight for *Health Care Freedom* to:

- **Give Seniors the same health coverage options Members of Congress have**
- **End the lawsuit insanity that's driving up our health care costs**
- **Protect patients' access to their doctors**
- **Ensure development of and access to innovative new medicines and technology**
- **Safeguard health care privacy**
- **Reduce Medicare bureaucracy, red tape, waste, and fraud**

www.unitedseniors.org **1-800-8-USA-USA**

LICENSED TO UNZ.ORG
ELECTRONIC REPRODUCTION PROHIBITED

State UPDATE

A monthly review of state health care activity

MANAGING EDITOR'S NOTE:
If you have news to share regarding legislative, political, legal, and business developments in your state's health care arena, please contact me at **meier@heartland.org**.

Spotlight on...

Washington

Governor Gary Locke (D) has proposed eliminating benefits for 60,000 childless adults in an effort to trim about $150 million from a state health program. State lawmakers instead are considering bills that would cut benefits across-the-board in order to keep more people in the program.

ARKANSAS

Preauthorization on Hold

The Department of Human Services has suspended for 60 days the requirement that claims for certain health services provided to Medicaid beneficiaries be pre-approved by First Health Services of Arkansas, with which the state contracted last April to review claims for children's mental health services in an effort to control Medicaid spending.

The action comes after several reports First Health is denying 40 to 75 percent of claims for children's mental health treatment. Some mental health facilities that continued to provide services even though claims were denied have reported losses of $150,000 a month.

The state and First Health have agreed to work with the five mental health centers with the highest denial rates to ensure providers understand the claims process and what services First Health considers medically necessary.

This is the second time the state has suspended the prior-approval system for Medicaid. The first suspension came last October, when mental health providers persuaded the department to suspend the system for 45 days.

Since it was launched, the pre-approval system has slowed the rate of Medicaid spending growth, from between 25 percent and 30 percent a year to just 8 percent.

Arkansas Democrat-Gazette
February 25, 2003

CONNECTICUT

Strange Bedfellows

Attorney General Richard Blumenthal (D) filed suit against Yale-New Haven Hospital for allegedly hoarding about $37 million in donations for the "free bed funds" intended to provide indigent patients free access to hospital care.

According to the lawsuit, the hospital impeded patients' access to the funds by providing minimal information about the funds and requiring patients to prove they were denied aid through local or state programs, a policy that prevented Medicare beneficiaries from applying for the funds to pay uncovered hospital balances. The lawsuit also alleges Yale-New Haven subjected patients to aggressive debt-collection practices when they were unable to pay their bills.

As a result of the hospital's failure to provide adequate notice of the funds' availability, only 55 patients on average apply for the funds annually.

The lawsuit seeks a judicial order requiring the hospital to provide information about the funds to every patient or potential patient who lacks health insurance or is otherwise unable to afford the hospital's services.

Blumenthal said, "We're complaining about more than simply accounting here. It's a fundamental breach of trust and moral as well as legal responsibility." Yale-New Haven officials said in a prepared statement that they were "shocked and surprised" by the lawsuit, adding the facility is the largest Medicaid provider in the state and gave more than $52 million in free or "under-compensated" care in 2002.

Blumenthal also testified before the state legislature's public health committee in support of a bill proposed by Senate Majority Leader Martin Looney (D) that would expand reporting requirements for hospitals with free bed funds and require greater patient notification.

Looney said a report-in-progress on the subject by the Federation of Hospital and University Employees, a group representing four Yale employee unions, and commissioned by the Connecticut Center for a New Economy, a local anti-poverty organization, led him to introduce the bill.

The report found Yale-New Haven spent 1.9 percent of its free bed funds in fiscal year 2001, compared with the approximately 5 percent some experts recommend charitable trusts spend from their principal each year. The report's preliminary findings were shared with Blumenthal's office several weeks ago, although it remains unclear to what extent the report influenced the attorney general's investigation.

New York Times
Hartford Courant
February 21, 2003

FLORIDA

Burley, Beer, and Burgers

John McMorran of Lakeland, the oldest living American man, died of heart failure at the age of 113 on February 24, 2003 after smoking cigars, drinking beer, and eating greasy food for much of his life, according to his 35-year-old great-granddaughter, Lisa Saxton. McMorran was born on June 19, 1889, in a log cabin in Michigan.

"He was never sick. He lived a great life," said Saxton. "Obviously, he was well-put-together." McMorran quit smoking at the age of 97 but continued to enjoy coffee and life. During his last few years, he was a celebrity of sorts, frequently making headlines marking yet another birthday.

In his later years, his eyesight failed, and he was hard of hearing, but he otherwise enjoyed good health until developing complications related to pneumonia.

According to official records, McMorran was the fourth-oldest person in the world. Japan's Kamato Hongo is the world's oldest person at 115.

Lakeland Ledger
February 25, 2003

ILLINOIS

Sounds Like Price Controls

The Senate Health and Human Services Committee unanimously passed SB 3, which creates a state-run prescription drug-buying club made up of seniors, people with disabilities, and possibly Medicaid beneficiaries.

Under the bill, the state would act as a negotiator for club members, who would pay a $25 annual fee. The club could reduce generic drug costs by up to 60 percent and name-brand drug costs by up to 20 percent, according to the bill's sponsor, Sen. Debbie Halvorson (D). However, Patty Schuh, an aide to Senate Minority Leader Frank Watson (R), asked, "One of the concerns we've had [is]: How do you afford it?"

Although she had no estimates on potential enrollment in her buying club, Halvorson said the $25 enrollment fee would cover the projected $27 million cost of the program. The bill leaves open the possibility that Medicaid beneficiaries could also be included in the program, a move drug companies say might violate federal law.

Noting the club could refuse to purchase drugs at unacceptable wholesale prices, Marjorie Powell, assistant general counsel to the Pharmaceutical Research and Manufacturers of America, said, "Federal law says

LICENSED TO UNZ.ORG
ELECTRONIC REPRODUCTION PROHIBITED

Compiled and Edited by Conrad F. Meier

Medicaid patients have to have access to all FDA-approved drugs." She added, "Our concern is mixing the interests of the Medicaid patients together with those of everybody else."

Chicago Tribune online
February 27, 2003

What's Wrong with this Picture?

The Republican-controlled legislature has made some hard choices in order to balance the state budget.

Over the years, the state's Democratic leadership had expanded eligibility for the State Children's Health Insurance Plan (SCHIP) significantly above the federally required level. Missouri's SCHIP plan was established in 1998 to provide health insurance coverage to children of families with incomes 186 to 300 percent above the federal poverty level. This unusually generous eligibility proved unsustainable and encouraged people to drop private and employer-sponsored health insurance.

Representative Chuck Purgason (R-Caulfield), chairman of the Social Services Appropriations Committee, pointed out that at 300 percent of the federal poverty level, families with incomes of $55,200 a year are eligible for government-run health care. The current SCHIP plan, he said, offers state money to families that can afford health insurance on their own. Purgason noted, "I would be eligible for the program six months from now if I dropped my state-employee health insurance plan today."

Purgason also said caseworkers from the Department of Social Services in his district told him of instances in which families with $191,000 in Certificates of Deposit in the bank were eligible for SCHIP. Mary Fallen, assistant deputy director for income maintenance, said a family's net worth of all available resources minus debts couldn't exceed $250,000 for the child to be eligible for benefits.

If Governor Bob Holden (D) signs the proposed budget plan, lowering SCHIP eligibility to the federal standard, thousands of children would lose insurance coverage. He is unlikely to do that. "This makes no budgetary sense, makes no economic sense, and makes no moral sense," Holden recently told legislators. He added the proposal "would not pass on my watch as Governor." The governor did not identify alternative cuts and stood by his plan to increase income taxes instead.

Purgason responded to the Governor's comments saying, "If that's immoral, I thinks it's immoral that he gives us a budget that's not balanced and is only balanced on increasing tax revenues that haven't passed yet."

House speaker Catherine Hanaway (R-St. Louis County) explained the state's budget shortfall makes it necessary to restore SCHIP eligibility to the federal level. "I'm not sure in very tough economic times we can be the insurance company for all those people."

Press Briefing
February 25, 2003
The Columbia Missourian
February 27, 2003

Telling it Like it Isn't

About 10,000 people in more than 150 New Hampshire cities and towns have approved a resolution stating voters' desire for elected officials to work toward more affordable health care.

The nonbinding resolution, circulated as part of a petition drive by New Hampshire for Health Care, states New Hampshire's health costs are the 12th highest nationally, that health plan premiums have increased 45 percent over three years, and that 77 percent of the 100,000 uninsured state residents are in families where at least one person works full-time.

Media coverage of the petition has failed to note New Hampshire is one of the country's most heavily mandated and insurance-regulated states.

Steve Bouchard, director of New Hampshire for Health Care, said the measure will not affect the state's finances. "This is merely a way to make our voices heard, to let people know the current health care system isn't working," he said. According to Bouchard, the group hopes the state's Presidential primary will draw national attention to the petition.

Curiously, the total reported membership of New Hampshire for Health Care is the same as the number of people who signed the petition to approve the resolution.

A statement on the New Hampshire for Health Care Web site notes, "Because of New Hampshire's unique position as the nation's first primary state, passing this resolution will also send a clear message to every Presidential candidate that visits our towns and cities over the next year that we want to know what their plan is."

While the statement carefully avoids any reference to support for single-payer health care—or any other health care plan—the rhetoric is similar to what surrounded last year's call for single-payer health care in Oregon. Moreover, the money trail leads to organized labor and single-payer advocates.

Portsmouth Herald
February 17 2003
New Hampshire for Health Care
New Hampshire Working Families of SEA
a project of the State Employees Association of New Hampshire, AFL-CIO

Not Eligible in the First Place

Last month, the state's Medicaid program began eliminating optional benefits for approximately 100,000 residents who didn't qualify for traditional Medicaid coverage in the first place.

Medicaid beneficiaries who have incomes below the federal poverty level but do not qualify for Medicaid will lose coverage for mental health and dental services, substance abuse treatment, and prescription drugs. Those beneficiaries will also be required to pay higher co-payments and premiums, including a new $250 charge for each hospital admission.

State lawmakers in 2001 approved a bill (HB 2519) to request a federal waiver allowing the state to split Medicaid into two tiers: Medicaid-Plus would cover individuals categorically eligible for traditional Medicaid, and Medicaid-Standard would cover residents who became eligible after the state expanded Medicaid coverage in 1994.

The *Portland Oregonian* reported five legislative committees will review plans to overhaul current arrangements and will report to the newly formed Oregon Health Plan Work Group. The group includes lawmakers, doctors, and representatives from the office of Governor Ted Kulongoski (D), the state Department of Health Services, hospitals, pharmaceutical companies, and health insurers.

Portland Oregonian
February 17, 2003
Kaiser Daily Health Policy Report
October 16, 2002

Medicaid in the Classroom

The *Pittsburgh Post-Gazette* has examined Pennsylvania school districts' increased use of Medicaid funds to pay for school activities. Under federal law, school employees who help Medicaid-eligible students and their parents determine if the family is eligible for Medicaid services, can record the time spent on such activities and then bill Medicaid.

Half of the money received for such claims goes to the state, while the other half can be used by the school districts "for any purpose ... for whatever the children need most," according to a statement by Rick Fellers, chief operations officer of the Pittsburgh school district. The investigative report revealed that last year, Pennsylvania schools billed Medicaid for $26 million in such charges—an $11 million increase over 2001.

Cathy Lynch of the Allegheny Intermediate Unit said while the program has been in effect since 1994, only 14 percent of the state's 654 districts use it because many school officials believe filling out the paperwork to receive the reimbursements is not "worth their time."

George Schneider, executive vice president of Leader Services, which administers the program for Pennsylvania and several other states, said the company "has become busier" recently because in the poor economy, "Schools are looking anywhere they can to find money."

Pittsburgh Post-Gazette
February 24, 2003

Using the Free-market Approach

Governor Gary Locke (D) has proposed eliminating benefits for 60,000 childless adults in an effort to trim about $150 million from a state health program. State lawmakers instead are considering bills that would cut benefits across-the-board in order to keep more people in the program.

The Senate Health Committee held hearings on two bills that would reform the Basic Health Plan, which provides health insurance to about 125,000 low-income residents who are ineligible for Medicaid. To qualify for the program, residents must have incomes less than 200 percent of the federal poverty level, or about $17,720 for an individual, and be ineligible for Medicaid.

About two-thirds of the current program participants, who pay minimal co-pays and premiums, are employed but do not have employer-sponsored health insurance.

SB 5313, sponsored by Sen. Jim Kastama (D), would reform the Basic Health Plan so it is similar to the Regence BlueShield FourFront plan offered in the private sector. The plan covers four physician visits per year, with co-payments of $15 per visit; up to $300 in preventative care costs per year; and up to $500 for laboratory or X-ray services. The plan also caps out-of-pocket costs at $2,500 per year. Under Kastama's measure, Basic Health would fully cover beneficiaries' preventative treatment costs, have a $3,000 annual deductible, and reduce income eligibility from 200 percent of the federal poverty level to 150 percent.

Locke said he directed the Health Care Authority to revamp Basic Health to make it similar to the FourFront model. State Rep. Eileen Cody (D) said modeling Basic Health after the FourFront plan could cut program costs by 25 percent and keep 15,000 people from losing benefits.

The second bill, SB 5807, introduced by Sen. Linda Evans Parlette (D), would limit beneficiaries' eligibility for the program to five years, lower income eligibility, and increase co-pays. Further details were not available as *Health Care News* went to press.

Associate Press
Seattle Post-Intelligencer

LICENSED TO UNZ.ORG
ELECTRONIC REPRODUCTION PROHIBITED

Think it only applies to criminals? Think again.

As of April 2003, every medical patient in the U.S. is subject to new regulations that give away your right to restrict the use of your private medical records.

Government agencies, insurance companies,

direct mail marketers, and law enforcement can look at your confidential information *without your consent* – even all of your old paper records from years ago and even psychiatric notes.

And your doctors' hands will be tied –

They'll have to hand them over. All you can hope for is a notice of where they might have gone…
UNLESS THEY REFUSE TO PARTICIPATE!

"YOU HAVE THE RIGHT TO REMAIN SILENT....

ANYTHING YOU SAY CAN AND WILL BE USED AGAINST YOU."

PATIENTS:
Ask your doctors to stay out. If not, ask to remove your records.

We'll give you the forms for your doctors.

DOCTORS:
Escape HIPAA and refuse to participate. We have all of the information and it's FREE – no expensive compliance programs or consultants.

It's all legal. You'll save money on compliance, avoid liability and exposure, and protect your patients' privacy!

For more information and a free copy of our ***Rx for Patient Power: The Patient's Handbook***:

AAPS

www.aapsonline.org
800.419.4777
The Association of American Physicians & Surgeons
The Voice for Private Physicians Since 1943

LICENSED TO UNZ.ORG
ELECTRONIC REPRODUCTION PROHIBITED

The Galen REPORT

A MONTHLY REVIEW OF HEALTH POLICY MATTERS

President Bush has fulfilled his promise to propose much-needed changes to the Medicare program, but his delay in providing details has put the White House on the defensive as the debate begins on this first-tier issue.

Political opponents and newspaper columnists around the country have filled the void with criticism of what is known about the plan, charging it will force seniors to lose their doctors and drive them into HMOs. It's not true, of course, but what does that matter in politics?

The President's vision is solid: Give seniors the choice of staying with traditional Medicare or selecting a new option that would allow them to join a competing health plan with drug coverage as part of the policy. The new plans would look more like Preferred Provider Organizations, in which seniors could select a plan whose provider network includes their preferred doctor or doctors.

The White House is struggling to keep domestic issues like health care in the spotlight, but it's extraordinarily difficult with the Columbia tragedy, the threat of war with Iraq, and North Korea dominating the news. The difficulty was evident the day after the President's State of the Union address. He delivered a speech that was billed as a major Medicare presentation ... but the President devoted only three minutes to the topic.

The President also has been criticized for not mentioning the uninsured in either speech, even though his budget devotes $89 billion over 10 years to refundable tax credits for health insurance. The budget is full of other provisions that cheer a free-market heart, like unshackling Medical Savings Accounts and making them permanent, giving states much more flexibility with Medicaid, and ending the use-it-or-lose-it provision for Flexible Spending Accounts so employees can rollover up to $500 a year.

There are a lot of good ideas out there, both inside and outside government, to fuel a substantive debate over health care. For example, in this issue of *Health Care News*, Tom Miller of the Cato Institute suggests linking Medicare payments to market prices and providing full cash rebates to seniors who choose plans that cost less.

Nevertheless, the debate is off to a rocky start.

U.K. Spin-Off Group

On a brighter note, as many of you know, the Galen Institute facilitates a group called the Health Policy Consensus Group that has been meeting since 1993. It's made up of the best minds in the market-based policy community and has been crucial in generating ideas that put consumers in the driver's seat in the health sector.

And now there is a new Health Policy Consensus Group formed in the United Kingdom and chaired by our friend Dr. David Green, director of the Institute for the Study of Civil Society in London. Like ours, the UK Consensus Group is diverse; it includes a mix of experts, from prominent Labour party members to representatives of market-oriented think tanks.

The U.K. group has developed a statement with six principles to guide reform, including advocating that "Patients should have a choice among a range of competing health care providers." As different as our systems are, we are both struggling to achieve the same goals. Congratulations and all success to this new Consensus Group.

- Grace-Marie Turner

RECENT NEWS ARTICLES & STUDIES

Reforming Medicaid

Michael Bond, John Goodman, Ronald Lindsey, and Richard Teske
National Center for Policy Analysis, February 2003

"It is likely that many taxpayers are paying more in taxes to fund health insurance for the poor than they pay for themselves and their own families," say John Goodman and coauthors in this paper outlining a pro-patient approach to Medicaid reform.

This year Medicaid will cost almost $1,000 for each person in the United States. Goodman and his colleagues recommend: 1) converting Medicaid into a defined-contribution system; 2) providing Medicaid enrollees with access to private health plans, including employer insurance; and 3) allowing the Medicaid benefit to be converted into private, portable insurance that can continue even after income levels exceed current Medicaid eligibility.

Their key principles for reform are choice, competition, portability, patient empowerment, paying for results, and devolution of control to local communities.

Full text (pdf version):
www.ncpa.org/pub/st/st257/st257.pdf

Treatment Denied: State Formularies and Cost Controls Restrict Access to Prescription Drugs

Linda Gorman
Washington Policy Center, February 2003

Prescription drug formularies are a cost containment tool used by health care payers that usually restrict the number and type of drugs covered, often favoring older and generic drugs. Many states have implemented restrictive formularies in an attempt to control Medicaid costs.

But Linda Gorman of Colorado's Independence Institute says this may actually increase health care costs in the long run. "Because the Medicaid population is sicker than the general population, political attempts to arbitrarily cap prescription drug spending run the risk of sending other health care costs out of control." A 1999 review of restrictive formularies by the National Pharmaceutical Council found that, "In general, formularies increase costs because overruling physician prescribing decisions increases the utilization of other forms of health care."

Additionally, physicians in Florida, which has a formulary, reported, "Medicaid patients were not getting the brand name medication that they needed, and that denials had resulted in negative clinical outcomes."

Full text:
www.washingtonpolicy.org/HealthCare/PBGormanTreatmentDenied.html

What Seniors Should Know about Government Restrictions on Prescription Drugs

Susan Horn Ph.D., Frederick Goodwin, M.D., and Robert Goldberg, Ph.D.
Heritage Foundation, November 2002

The revelation that drug formularies limit patient choice of needed drugs, decrease health outcomes, and lead to higher health care costs in the long run is not a new one. Dr. Susan Horn, senior scientist for the Institute for Clinical Outcomes Research in Utah, conducted a study of 13,000 patients from six HMOs, titled the Managed Care Outcomes Project.

This study found that more restrictive drug formularies were correlated with an increase in patients' use of more expensive medical services, treatment in emergency rooms and hospitals, and visits to doctors' offices. Horn also recently coauthored a Heritage Foundation paper that found restrictive drug formularies have a greater negative impact on senior citizens than on younger ones, a warning to those who would design a Medicare drug benefit.

Full text: **http://www.heritage.org/Research/HealthCare/bg1611.cfm**

Material for this report is provided by The Galen Institute, P.O. Box 19080, Alexandria, VA 22320, **http://www.galen.org**. *Grace-Marie Turner is president. The report was produced by Elizabeth Lamirand, who can be reached at 703/299-9550, and edited by Conrad F. Meier, managing editor of* Health Care News.

LICENSED TO UNZ.ORG
ELECTRONIC REPRODUCTION PROHIBITED

My TURN

BY CONRAD MEIER - MANAGING EDITOR

Bloodletting Doesn't Work!

Conrad F. Meier

Beware policymakers who still believe the centuries-old practice of bloodletting is an acceptable medical procedure for treatment of a patient bleeding to death.

Once again, federal lawmakers are heading into the operating room to treat the hemorrhaging U.S. health care system. The congressional schedule is getting jammed with new patients' bills of rights, single-payer health care plans, expansion of mental health parity legislation, and malpractice reform legislation.

Rights Still Wrong

Rep. Charlie Norwood (R-Georgia) is trying to resuscitate the old Patients' Bill of Rights Act by calling it the Patient Protection Act (PPA). Among the so-called "patient protections" is a costly mandate forcing managed care insurance plans to provide access to prescription drugs.

A second Norwood bill attempts to clarify that the 1974 Employee Retirement Income Security Act (ERISA) does not protect employers with self-funded insurance plans against lawsuits stemming from denials of care initiated by the plan's insurance company or the firm's health plan administrator.

Senators John McCain (R-Arizona), John Edwards (D-North Carolina), and Edward Kennedy (D-Massachusetts) and Representative John Dingell (D-Michigan) also are expected to enter the operating room and propose their own patients' rights redux.

Exorcising ClintonCare

Representatives John Conyers (D-Michigan) and Jim McDermott (D-Washington) are attempting major surgery with a bill to create a national single-payer health system. Conyers, upon recently awakening from hibernation, said, "Even the people who don't like a single-payer system, are moving to it. There's nothing else left."

McDermott, like Conyers, is apparently unaware of the trashing single-payer took late last year in Oregon, or that a major shift to consumer-driven health care is taking place even as they attempt to switch us all to socialized medicine. According to a bill summary, the Conyers/McDermott plan would extend the current Medicare system to all U.S. residents by increasing existing Medicare payroll taxes and adding a new payroll tax as yet undefined. Kennedy, not to be out-maneuvered, plans to introduce similar legislation.

Analyze this

Senators Pete Domenici (R-New Mexico) and Kennedy (again), along with Representatives Jim Ramstad (R-Minnesota) and Patrick Kennedy (D-Rhode Island), want their new bill to expand the Mental Health Parity Act of 1996. This little piece of bloodletting, called the "Senator Paul Wellstone Mental Health Equitable Treatment Act of 2003," would amend a 1996 law that says health plans covering mental illnesses may not establish different annual and lifetime benefits for mental illnesses than for physical illnesses.

Under the new legislation, those health plans also would be forbidden from establishing higher deductibles or co-payments for mental health benefits than for other medical conditions.

One Last Incision

Malpractice bills introduced by Kennedy and McCain would rely much more heavily on lawsuits than a competing bill by Senators John Breaux (D-Louisiana) and Bill Frist (R-Tennessee). Nevertheless, the potential for increased litigation under each of these bills could further shorten the life of many health plans and divert billions of dollars more from health care to litigation.

Code Blue

Our health care system is experiencing cardiac arrest. Before we can expect any improvement in its condition, the patient must be stabilized. The way to do that is not to create *more* stress on the system, by expanding its girth or burdening it with new regulatory demands, but to understand what's causing the stress in the first place.

The legislative approaches described here are exceedingly stressful in that they represent unfunded and procedural mandates on a health care system already over-regulated. The U.S. health care system can take no more such stress. At best, these proposals are obstructionist measures obviously designed to pander to a special constituency; at worst, they are designed to further destabilize the private-sector health care industry, clearing the way for socialized medicine.

Give Freedom a Chance

If the U.S. health care system is to survive, lawmakers must pass the structural reforms needed to correct Medicare; expand state authority over Medicaid; define a workable malpractice system; expand access to affordable health insurance with tax credits and Medical Savings Accounts; and create a prescription drug plan that responds to consumer demand, not regulatory demand or price controls.

The long-term solution is to allow patient-consumers to stand on their own two feet, to choose and own their own health insurance—just as they choose and own their life, long-term care, retirement annuity, home, and auto insurance.

The 108th Congress already has before it the tools it needs to return the U.S. health care system to its vital self, legislation that can unleash the free market and restore freedom of choice. But the stress-inducing measures discussed here have got to go.

Conrad F. Meier is managing editor of Health Care News.

Support *Health Care News*! Become a Heartland member and donor.

Health Care News focuses on the most promising market-based solutions to health care problems, including:

- Medical savings accounts
- Repeal of mandates
- Tax fairness
- Competition and choice
- Defined contribution insurance

Free copies of *Health Care News* are sent each month to every state and national elected official in the U.S. and thousands of doctors, insurance brokers, policy analysts, and pharmacists who share an interest in market-based reform. Please complete and return the form below if you wish to continue receiving this publication, and urge your friends and colleagues to fill out and return forms too.

HCN4/03

The Heartland Institute is an independent nonprofit organization founded in 1984. Contributions are tax deductible under Section 501(c)3 of the Internal Revenue Code.

Please return form to:
The Heartland Institute
19 South LaSalle Street
Suite 903
Chicago, Illinois 60603
fax 312•377•5000.

Membership
❑ $29
❑ $49

Subscription
❑ $24

Additional Contribution
❑ $1,000 ❑ $100
❑ $500 ❑ $50
❑ $250 ❑ $25
❑ Other _____

❑ My check in the amount of $_____ is enclosed.
❑ Charge $ _____ to my ❑ Visa ❑ MC ❑ Am Ex
Account Number _____
Expiration Date _____
Signature _____

Name _____ Home Phone _____
Title•Company _____ Work Phone _____
Address _____
City•State•Zip _____

❑ *Please send me additional information about The Heartland Institute.* ❑ *Please send me information about advertising in HCN.*

LICENSED TO UNZ.ORG
ELECTRONIC REPRODUCTION PROHIBITED

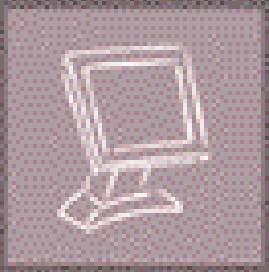
TEPR '03

19TH ANNUAL CONFERENCE & EXHIBITION

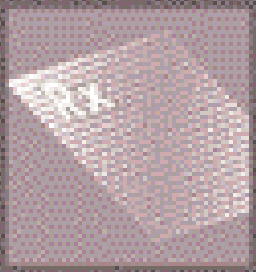
Electronic Patient Management

May 10–15, 2003
San Antonio Convention Center, Texas

4 COMPLETE CONFERENCES IN ONE VENUE

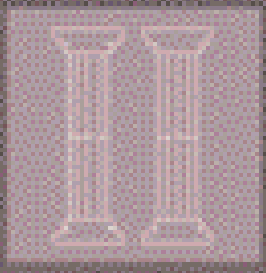


1 EHR SYSTEMS, IT TOOLS & SECURITY:
Electronic Health Record Systems – Outpatient and Inpatient IT Solutions



2 ELECTRONIC ORDER ENTRY:
Developing and Implementing a Component Strategy, Driving Adoption and Clinical Decision Support

3 MOBILE HEALTH CARE:
Designing Mobile Strategy, Overcoming Technical Barriers, and Real Life Examples of What Works



4 e-HEALTH LEGAL FORUM:
Addressing the Legal Risks Associated with the Exchange of Patient Information: Who is Responsible? Civil Law, Avoiding Malpractice and Mock Trials

CME Accreditation Pending

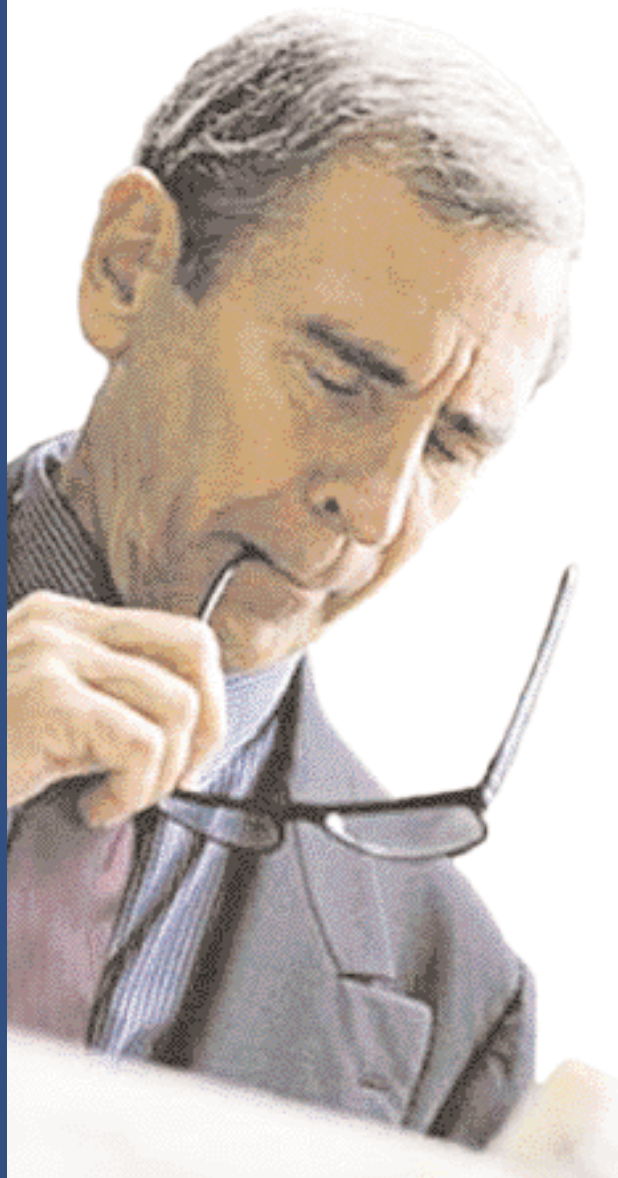
Register at www.tepr.com
Call 617-964-2947 for more information

LICENSED TO UNZ.ORG
ELECTRONIC REPRODUCTION PROHIBITED

50% OFF

All ads in the June issue of

Health Care News



1/2 page $675.00 (reg. $1,350)

Junior page $818.00 (reg. $1,636)

Full page $1,350.00 (reg. 2,700)

It's easy as 1,2,3!

1. Reserve your ad space by April 30.
2. Provide us with camera-ready material by May 5.
3. Sit back and watch all the new customers, sales, and profits roll in!

DON'T MISS THIS OPPORTUNITY!

Call Nikki to reserve your space today!
312.377.4000
email Nikki@heartland.org

LICENSED TO UNZ.ORG
ELECTRONIC REPRODUCTION PROHIBITED